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The Lived Experiences of Clinicians Who Treat Black Males Who Have Experienced Intimate Partner Violence

Gifty A. Acheampong
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Walden University

College of Psychology and Community Services

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Gifty Ama Acheampong

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Walden University
2025

Abstract

The Lived Experiences of Clinicians Who Treat Black Males Who Have Experienced

Intimate Partner Violence

by

Gifty Ama Acheampong

MA, Walden University, 2019

BS, Midwestern State University, 2015

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

Walden University

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Abstract

Intimate partner violence (IPV) is a global issue that negatively affects humanity. The harmful effects of IPV often result in lifelong consequences for victims. Researchers have consistently identified women and children as the primary victims of IPV, although men can also be affected. The social stigma around men seeking formal help as victims is that they must endure physical, emotional, financial, sexual, and psychological abuse in intimate relationships. Because psychological abuse is the most common form experienced by male IPV victims, there is a higher prevalence of IPV within the Black community. However, research on help-seeking behaviors among Black men in mental health remains limited. This qualitative study explored the lived experiences of clinicians who treat Black men affected by IPV. The study was guided by Sue's multidimensional cultural competency, which emphasizes multicultural competence in psychology at the individual, professional, organizational, and academic levels. The study involved nine English-speaking clinicians working with Black male IPV victims. Data were collected through semistructured interviews via Zoom, using open-ended questions. Results indicated that clinicians often lack sufficient training, resources, and access to education necessary to effectively treat Black male IPV victims. These findings highlight the need for developing targeted training and resources tailored to their unique needs.

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Dedication

To God-Christ, the sustainer of my mind and the keeper of my soul, thank you. To my son Zahrius, my dear beloved, I wouldn't be where I am without your help. You have been my backbone since you were old enough to reach out and support me. Your unwavering love, patience, kindness, and resilience have been my strength. Your sister and I are forever grateful. I leave you with Numbers 6:24-25. Always remember that you owe nothing to anyone but to God—everything. Always put Him first, and He will make your path straight.

To my daughter, Nazareth. Dear Nazy, Now I can be a full-time mom to you. Nazy, you have my undivided attention now. You no longer have to say, "You said that last year, and the years before, and you will say that next year." Your wit and persistence have been my driving force to persevere. Thank you for walking on my back to loosen up the knots from hours of sitting and writing. Now, that is a true Ghanaian massage. Your soft footsteps on my back have done me some wonders. Nazy, "Can anything good come out of Nazareth?" John 1:46. We know what good came from Nazareth. Lead by His example. Forever love, Mom.

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Words cannot express my gratitude. God never makes mistakes. He placed you in my path not only as a teacher but also as a mentor and leader. When I felt like I was sinking, you were always there, lifting me with hope. There were times when I sank, and you picked me up. I couldn't have done it without you. You even sacrificed your early bedtime when I needed you most. Your selfless act of kindness, along with your feedback, guidance, and gentle prompts, gave me hope and encouragement, and you challenged me. There were times I wanted to quit, but you kept cheering me on. For that, I thank you.

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I am honored to have you as my second committee member. Your wealth of knowledge has helped me mature. You empowered me to be my best with grace, compassion, and sincerity. All the feedback you provided was meant to challenge me and broaden my perspective through a different lens. Thank you for my growth.

To my participants, your invaluable time will never go unnoticed. This study wouldn't have been possible without you. My gratitude to each of you.

To my praying warriors, thank you for all the prayers for my family. Lastly, to men in abusive relationships, you do matter. Continue to speak until your voice is heard.

To all clinicians, continue to walk in your calling and in your purpose.

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Chapter 1: Introduction to the Study

Intimate partner violence (IPV) is a worldwide issue. IPV is also the most common form of abuse experienced by men and women in intimate relationships (World Health Organization [WHO], 2017). Once thought to be a marital problem between husband and wife (Martin, 1976), IPV now affects individuals from various racial, cultural, ethnic, gender, and socioeconomic backgrounds (Langhinrichsen-Rohling et al., 2012; A. Machado et al., 2016; WHO, 2017, 2021). Researchers have found that IPV leads to negative psychological and emotional issues for offenders and victims (D.E. Reidy et al., 2014; Scott-Storey et al., 2022; Taylor et al., 2022). However, most studies have focused on women's mental, physical, and social health problems (Ahmadabadi et al., 2017; M.E. Bagwell-Gray, 2021; Bott et al., 2019; Reid et al., 2008). Although research showed that men experience IPV at a rate similar to women (Archer, 2000; Kolbe & Büttner, 2020; Leemis et al., 2022; P. Tjaden & Thoennes, 2000), evidence also indicated that men can experience physical, emotional, psychological, sexual, and financial abuse by their partners (E.A. Bates et al., 2019; Bates, 2020a, 2020b; A.L. Coker et al., 2021; Scott-Storey et al., 2022).

Furthermore, researchers suggested that formal help-seeking is influenced by society's limited awareness of and support for men in IPV relationships (Hine et al., 2022; K.F. Hogan et al., 2021). Nonetheless, the type of formal help available depends on the social demographics of the victim, including their race, culture, gender, sexual orientation, and ethnicity (Chen et al., 2020; King et al., 2021). Scholars have noted that

women experiencing IPV can access therapeutic counseling (Karakurt et al., 2022; A. Lysova et al., 2020; L. Tarzia et al., 2020; Taylor et al., 2022; A. Walker et al., 2020). However, for male victims of IPV, the literature indicated that underlying issues such as systematic prejudice, stereotypes, racism, and discrimination are responses of service providers, including social workers, psychologists, counselors, law enforcement officers, and mental health providers (Backes et al., 2020; Bartholomew et al., 2023; E.A. Bates et al., 2019; Bates, 2020a, 2020b; Follingstad et al., 2004; Hulley et al., 2023; Rettig, 1990). Nevertheless, men's reluctance to seek formal help is often linked to the preservation of masculinity (R. Connell, 2005; R.W. Connell & Messerschmidt, 2005).

As a result, these experiences elevate the risk of men staying in abusive relationships (Bates, 2020a, 2020b; Hine et al., 2022; Hulley et al., 2023; Satyen et al., 2019). Researchers have indicated that, overall, there are few intervention programs designed to address IPV among racial minority groups (Emezue et al., 2021; E.W. Gandolf & Williams, 2001; A.L. Reynolds & Pope, 1991; Sue, 2001). For ethnic minorities, the absence of culturally appropriate programs has often resulted in Black men being placed in conventional counseling programs meant for European American men (E.W. Gandolf, 2008; E.W. Gandolf & Williams, 2001; Hulley et al., 2023; Jun, 2024; Moore et al., 2021; D.W. Sue et al., 2024). Based on these reports, formal help-seeking processes highlight the importance of clinicians in treating male victims of IPV. Despite my extensive review of the literature on clinicians' experiences with treating

Black male IPV victims, there was no literature specific to my topic. Therefore, I relied on seminary work for my study.

In this study, I explored the lived experiences of clinicians who work with Black male victims of IPV. This research could promote positive social change by establishing a foundation for developing culturally sensitive programs that address the cultural challenges faced by clinicians. Additionally, the findings may serve as a basis for designing programs that enhance cultural competence among mental health providers, organizations, agencies, and educational institutions. Finally, the results could help policymakers support and promote programs focused on multicultural counseling in clinical practice, thereby improving the effectiveness of clinical services.

Background

IPV against men is not a new phenomenon. Although IPV is an abuse faced by men and women, the literature showed that men are less likely to seek help despite the negative effects on their physical, psychological, and mental health (Good & Robertson, 2010). Researchers have observed that men's reluctance to seek help is influenced by social norms related to traditional gender roles of masculinity and femininity (Harrington et al., 2021; Stanziani et al., 2019). For male victims of IPV, maintaining masculinity often involves embracing strength, bravery, toughness, independence, restrained emotionality, inhibited affection, and resilience (Levant & Pryor, 2020; Rowland, 2021). Therefore, any deviation from these societal expectations is viewed as inferior and an insult to their self-image and masculinity. Studies indicated that men's difficulty in

recognizing abuse in intimate relationships contributes to their reluctance to seek help (Morgan & Wells, 2016). This concept of gender roles further intensifies men's hesitance to seek and accept assistance (Lopez Maestre, 2020), along with the negative responses from service providers.

Nevertheless, the evolving research to include men as victims of IPV has encouraged researchers to explore the help-seeking experiences of male IPV victims. A. Walker et al. (2020) explored Australian men's experiences with female-perpetrated IPV, using the term "boundary crossings" instead of domestic violence or IPV. *Boundary crossing* is defined as "any behavior that violates or restricts a person's right or safety, self-determination, self-esteem, privacy, reputation, or self-expression" (A. Walker et al., 2020, p. 215). A. Walker et al.'s study revealed that men's experiences of IPV are related to their female partners crossing boundaries. A. Walker et al. (2020) noted that boundary crossing involved physical violence, assault, sexual violence, controlling behavior, manipulation, domination, verbal aggression, and abuse. The narrative of participants indicated that men were threatened with knives, kicked, punched, humiliated, and emotionally blackmailed by their partners (A. Walker et al., 2020). Furthermore, the findings from Morgan and Wells (2016) echo those of A. Walker et al., with male participants, indicated that their partners used control to overpower them.

J. Rodriguez et al. (2021) conducted an 8-week study on heterosexual couples to examine perspectives on the use of aggression in intimate partner relationships. The results showed that, on average, men experienced more days of aggression than their

female partners, with men reporting 11 days compared to 8.9 days for women.

Additionally, men reported experiencing physical violence more than women reported experiencing it. J. Rodriguez et al. also noted that behavioral boundaries often led to physical and verbal aggression, and both men and women reported using physical violence—such as pushing, slapping, grabbing, and punching—toward their partners.

Riggs et al. (2000) reported that psychological problems served as risk markers for IPV perpetration and victimization. Keilholtz and Spencer (2022) identified mental health distress as the second strongest risk marker for physical IPV perpetration and victimization among IPV victims. Regarding the impact of IPV on mental health, Bates (2020b) highlighted psychological factors such as fear, shame, and guilt that increase the risk of suicide, post-traumatic stress disorder (PTSD), depression, and anxiety among male victims. A. Lysova et al. (2020) found that alienation from children and difficulty in forming new romantic relationships negatively affected men's mental health. Additionally, trust issues were identified as barriers to developing new relationships and as factors contributing to a higher risk of suicidality among men (E.A. Bates et al., 2019; Bates, 2020a, 2020b; Scott-Storey et al., 2022).

Concerning help-seeking among victims of IPV, cultural norms, customs, and sociodemographic factors have been recognized as barriers to help-seeking among ethnic minorities (Satyen et al., 2019). Overstreet and Quinn (2013) identified cultural stigma, stigma internalization, and anticipated stigma as three factors that hinder help-seeking behavior for IPV victims. Cultural stigma refers to society's negative attitudes and beliefs

that discredit the experiences of IPV victims (Overstreet & Quinn, 2013). Stigma internalization is the process by which IPV victims accept the abuse as their own fault, influenced by societal stereotypes (Overstreet & Quinn, 2013). Lastly, anticipated stigma involves expecting negative reactions once others learn about the abuse (Overstreet & Quinn, 2013). Rai and Cho (2022) reported that the lack of culturally appropriate services for ethnic minorities acts as a barrier to formal help-seeking among minority women. M. A. Rodriguez et al. (1999) identified communication issues with clinicians as a barrier for IPV victims seeking help. Specifically, for female IPV victims, seeking formal counseling and support services was a known obstacle. K.R. Henning and Klesges (2002) found that 14.9% of IPV women sought formal assistance through counseling and support services.

The research indicated that most existing literature concentrated on the help-seeking behaviors of female victims of IPV (Barner & Carney, 2011; Botts et al., 2019; Browne, 1993). Support for the effectiveness of services for Black male IPV victims was limited from the clinician's perspective. This gap was what the current study aimed to address.

Problem Statement

Over the past few decades, researchers have concentrated on understanding the prevalence of IPV, raising awareness, and enhancing services and resources for victims (Barner & Carney, 2011; Banks, 1999; Botts et al., 2019). However, most studies have primarily focused on IPV against women (Ade et al., 2021; Ahmadabadi et al., 2017;

Alhabib et al., 2010). The existing research mainly examined clinicians' experiences who worked with perpetrators and survivors of domestic violence (Iliffe & Steed, 2000).

There is limited research on clinicians' lived experiences who worked with Black male IPV victims seeking help. Researchers have identified numerous barriers that prevented male IPV victims from seeking assistance (Bates, 2020a, 2020b; Huntley et al., 2019; A. Machado et al., 2016; Taylor et al., 2022). Among these barriers, scholars suggested that internal and external factors influenced formal help-seeking behaviors in male IPV victims (A. Lysova et al., 2020). Internal factors, such as embarrassment, fear, shame, and interpersonal conflicts, contributed to victims remaining in IPV relationships (A. Lysova et al., 2020; Scott-Storey et al., 2022; A. Walker et al., 2020). External factors involved challenges in accessing professional services, resources, and programs available to women who are abused (Crowe & Murray, 2015; A. Lysova et al., 2020). Within the criminal justice system, men have reported negative experiences with law enforcement, which sometimes resulted in their arrest when they sought help (Barkhuizen, 2015; E. Buzawa & Hotaling, 2006; E. Buzawa et al., 2007; Dim & Lysova, 2022; H. Douglas, 2018; D.A. Hines et al., 2015; Lantz et al., 2023). Research also indicated that men are more likely to face administrative abuse of power within the judiciary system compared to women (Dim & Lysova, 2022). Additionally, scholars pointed out that men have lost custodial rights to their children due to false allegations made by their female partners (Cunha et al., 2023; D.A. Hines & Douglas, 2010; D. Hines & Douglas, 2009).

Research into health care systems has identified knowledge gaps as barriers to help-seeking for IPV victims. According to V. Lavis et al. (2005), a focus on symptomatology has caused health care providers to overlook the issue of IPV. McCall-Hosenfeld et al. (2014) found that health care professionals, including doctors, nurse practitioners, physician assistants, and nurses, reported low confidence in assessing victims of IPV. The authors noted the lack of training, high workload, limited access to referral services, and the desire to maintain patient-provider relationships were factors that influenced professional responses to victims experiencing IPV (McCall-Hosenfeld et al., 2014). M.A. Rodriguez et al. (1999) echoed these findings. According to the authors, major barriers to intervention included perceived lack of time, insufficient information about local community agencies and resources, and physicians' lack of confidence in making a difference for IPV victims (M.A. Rodriguez et al., 2001). Furthermore, M.A. Rodriguez et al. discovered that physicians' concerns regarding patients' fears of police involvement, inadequate follow-up on referrals, and cultural differences between patients and providers also served as significant barriers to intervention.

The identified barriers to formal help-seeking among Black male victims explained why this study was conducted to understand clinicians' lived experiences as service providers to Black male IPV victims. Although research has examined clinicians' experiences who worked with perpetrators and survivors of domestic violence, no studies were found to explore the lived experiences of clinicians who treat Black males who have experienced IPV. This gap was addressed in the study.

Purpose of the Study

Researched studies have documented men's ambivalence toward seeking professional services as victims of IPV (E.A. Bates et al., 2019; Bates, 2020a, 2020b; Brooks et al., 2020). Findings from these studies have shown that attitudes of professionals, lack of resources, and societal acceptance were barriers to formal help-seeking among male IPV victims (E.A. Bates et al., 2019; Crowe & Murray, 2015; E. Douglas & Hines, 2011). Additionally, limited access to suitable programs, services, and resources impacted help-seeking behaviors among ethnic groups (Hilbert & Krishnan, 2000; Rai & Cho et al., 2022). For Black male IPV victims, the limited availability of multicultural mental health treatment resulted in this group being underserved (E.W. Gandolf & Williams, 2001). These challenges, along with the cultural stigma associated with Black men being perpetrators of abuse, influenced their likelihood of seeking help compared to their White counterparts. Research indicated that in clinical settings, Black individuals have failed to meet therapeutic standards on a continuum scale based on race, culture, ethnicity, and dialect (Bloombaum, 1968). Although Black women are more accepted in therapy than Black men (Eckhardt et al., 2013; Woodward, 2011), studies suggested that Black men encountered greater discriminatory attitudes from therapists during formal help-seeking (Bloombaum, 1968; Eckhardt et al., 2013; Woodward, 2011).

In this qualitative study, I explored the lived experiences of clinicians who treated Black males who have experienced IPV. The research methodology I used to guide this study is IPA. I used IPA to enable a deep and rich understanding of clinicians'

lived experiences. IPA allowed me to explore clinicians' perspectives to gain a more detailed and comprehensive understanding of their experiences, viewpoints, and challenges faced as mental health providers. Additionally, the information collected could be used to inform policymakers about developing programs and providing access to resources that enhance clinicians' multicultural competency in clinical settings. Furthermore, the results could be utilized by institutions, organizations, and academia to develop culturally inclusive programs that aim to improve formal help-seeking among Black men. This study was based on Sue's (2001) multidimensional cultural competency. I obtained the data through semistructured interviews with clinicians, who are mental health providers.

Research Question

What are the lived experiences of clinicians who treat Black males who have experienced intimate partner violence?

Theoretical Framework

The study was based on Sue's (2001) multidimensional cultural competency. Sue's model focused on three key dimensions of multicultural competency essential in psychology. The first dimension included the individual and professional levels. For mental health providers, Sue argued that unaddressed personal values, beliefs, biases, and misconceptions about race, culture, gender, and ethnicity impacted treatment outcomes (Sue, 2001). According to Sue, multicultural competency in psychology was beyond skin color, race, and ethnicity (Sue, 2001). Sue advocated for clinicians to engage in self-

reflection to identify and address ingrained prejudices and biases, thereby improving their ability to meet the clinical needs of ethnic minorities (Sue, 2001).

At the professional level, a multicultural treatment approach should be encouraged and supported in clinical counseling. Clinicians should be permitted to incorporate individual races, cultures, beliefs, and practices into counseling without strict adherence to APA standards of practice (Ethical Principles of Psychologists and Code of Conduct, 2002). The rigidity of clinicians to practice within the confines of APA guidelines limits therapeutic outcomes for ethnic groups in conventional counseling (E.W. Gandolf & Williams, 2001). Multicultural competency could be promoted at the organizational level when the mental health crisis in Black communities that lack culturally appropriate programs and Black therapists is addressed (Sue, 2001). Finally, eliminating cultural disparities and promoting clinicians' multicultural competency for minority groups could be achieved by changing social policies that marginalized Black communities from access to resources and programs available to their White counterparts (Sue, 2001).

Nature of the Study

In this qualitative study, I explored the lived experiences of clinicians who treat Black males who have experienced IPV. I used IPA to provide an understanding of clinicians' lived experiences. IPA was suitable for the study because it guided the research question, data collection, interpretation, and analysis of the results. Because IPA addressed both idiographic and hermeneutic aspects in a qualitative study, this approach

allowed me to examine an in-depth account of each participant's lived experiences (J.A. Smith 2017).

IPA was hermeneutic because it emphasized the detailed study of lived experiences, their meanings, and how participants interpreted their experiences without changing the context or meaning to match the researcher's expectations. In other words, I accepted the face value of both the objectivity and subjective experiences of participants (J.A. Smith, 2017). In this study, I used open-ended questions in semistructured interviews and gathered rich, detailed responses from participants (J.A. Smith, 2017). Interviews were audio-recorded and transcribed verbatim for analysis. Because IPA studies are typically conducted with small sample sizes (J.A. Smith, 2017), I conducted nine interviews with English-speaking mental health providers to gain insight into their lived experiences. Participants were chosen through purposeful and snowball sampling. Purposeful sampling enabled me to select participants who fit the study criteria, while existing participants referred colleagues who also met the criteria to participate (Patton, 2014). Participants were recruited from various online platforms via email and phone calls.

Definitions of Key Terms

Clinicians or clinical counselors include social workers, psychologists, mental health providers, therapists, and psychiatrists. The services these professionals provide focus on addressing a client's personal or emotional struggles. The goals of these services are to help clients achieve greater self-acceptance, better reality orientation, improved

decision-making skills, and enhanced effectiveness in interpersonal relationships. They achieve this by identifying the client's primary issue through gathering information, interpreting the data, and developing and implementing a treatment plan (A.L. Reynolds, 2001).

Cultural competency encompasses a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals. These principles enable clinicians and individuals to work effectively across cultures with people from diverse racial and ethnic backgrounds. Being culturally competent involves honoring and respecting the beliefs, language, and interpersonal styles of individuals and groups, both individually and collectively. Cultural competency is not a fixed entity; it develops over time along a continuum. It is also a dynamic, ongoing, developmental process that requires a long-term commitment to the services provided (Bragdon et al., 1998; Blanchet Garneau, & Pepin, 2015).

Culture encompasses the collection of meanings that shape a way of life, influenced by attributes like history, language, religion, tradition, and culture itself (Christopher et al., 2014).

Ethnicity refers to the traits of people who share cultural beliefs in language, food, music, dress, values, and beliefs related to common ancestry and shared history (Floreani, 2013).

Formal help support refers to the broad category of professional services funded by help-seeking efforts. These include health professionals, the police, lawyers,

community or family centers and organizations, women's and men's centers or support groups, shelters, crisis centers, psychotherapists, medication, psychiatry, mental health services, and victim services (J.L. Berger et al., 2013).

Gender refers to the physiological and physical characteristics associated with behavior, personality, and expression that are conventionally labeled as feminine or masculine (Lindqvist et al., 2021).

Help-seeking for mental health involves an action or activity where an individual perceives the need for personal, psychological, emotional, or social support, care, or services to positively address mental health issues. (Problems can be defined as any action or activity carried out by individuals who perceive themselves as needing personal, psychological, emotional, or social support, care, or services to meet needs positively (Dim & Lysova, 2022).)

Informal help and support refer to services and assistance often provided by family, friends, neighbors, and coworkers (Ansara & Hindin, 2010).

Intimate partner violence refers to behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors involving violence by both current and former spouses and partners (WHO, 2017).

Lived experience refers to an individual's personal experiences and stories describing a complex phenomenon (Mapp, 2008).

Male victimization involves men enduring physical, psychological, financial, and emotional abuse from former female partners (Carmo et al., 2011).

Masculinity is the social construct of men's cultural behaviors and practices that subordinate and shape men's social relationships with women, other men, and themselves (R. Connell, 2005; McGinley & Cooper, 2013).

Mental health providers include social workers, psychologists, psychiatrists, and psychiatric mental health nurse practitioners. These licensed professional counselors, therapists, psychologists, and mental health practitioners work with clients from diverse racial, ethnic, and cultural backgrounds in therapeutic counseling (Krupnick et al., 1996).

Minority groups are people characterized by a specific trait that represents less than half of the individuals in each context, whose lifestyles differ from those of the dominant group (Eduardo & Ruiz, 2016).

Multicultural counseling is a type of therapy where the therapist, in a helping role, applies specific goals that align with the client's lived experiences and cultural values. The counselor and their profession use both universal and culturally specific helping strategies and roles to recognize the client's identity, which includes the individual, group, and broader cultural dimensions. This process occurs through assessment, diagnosis, and treatment of the client and their systems (D.W. Sue & Torino, 2005).

Partner refers to a heterosexual or homosexual individual in a marriage, dating, or cohabiting relationship (Nicolaidis & Paranjape, 2009).

Race refers to socially constructed categories based on skin color, physical features, and language, which form the basis of cultural and psychological diversity within a racial group (Franklin, 2011).

Assumptions

In this study, I used IPA to understand the lived experiences of clinicians who have treated Black male IPV victims. Several assumptions were made with this research. I assumed that the inclusion criteria would select participants with a master's degree in counseling and relevant experience related to the studied phenomena. I trusted that the ethical integrity of the findings would ensure they accurately reflected the participants' experiences (J.A. Smith et al., 2012). Further, I assumed that the research participants would be honest about their eligibility and demonstrate sincerity and transparency in their responses to interview questions. Additionally, I assured the participants that their anonymity would be maintained and that all information provided would be stored securely in a locked cabinet, with access strictly limited to me. Lastly, I engaged in continuous self-reflection to ensure objectivity, acknowledging and managing my own cultural and social biases during the research process.

Scope and Delimitations

The participants selected for this study were clinicians from a homogeneous group. A homogeneous sample was necessary because the research problem was specific to this group. Clinicians encompass a diverse range of licensed mental health professionals, including the following: social workers, counselors, psychologists,

therapists, psychotherapists, mental health practitioners, and psychiatrists (Pedersen, 1997). I focused on this group of professionals to gain comprehensive knowledge, insights, and understanding of their experiences as service providers to Black men. The study's limitation was that clinicians had to have treated Black male victims of IPV. To meet ethical standards, clinicians who did not meet this criterion and professional colleagues were excluded.

Limitations

Every study has certain limitations and weaknesses. In this study, I explored clinicians' experiences who treat Black males who have experienced IPV. One limitation of this study was its geographical scope, as it was limited to participants in two states. Although the study was open to clinicians across 50 states in the U.S., I was only able to recruit participants from two states (Texas and Chicago). The sample size was determined by the number of participants needed to achieve data saturation. I stopped recruiting once I reached data saturation with nine participants. Another limitation was that participants' biases may have influenced their experiences working with abused Black men. Due to the small sample size, the applicability of the results is restricted to the specific study population. Therefore, the generalizability of the findings to other populations and settings was limited

Significance

Male victims of IPV are faced with numerous barriers when seeking formal help. While female victims of IPV generally have easier access to formal support, research

indicated that various factors hindered male victims from obtaining help. Besides physical abuse, psychological abuse is often more damaging to men's mental health. However, few studies have explored formal help-seeking from mental health providers, and no research was found to examine clinicians' lived experiences who treat Black male victims of IPV. Therefore, the significance of this study lies in its potential contribution to an emerging field, as it explored clinicians' experiences with this population. The positive social change that could result from this research includes increased awareness of the challenges clinicians face when treating Black male victims of IPV. It could also raise awareness among the public and professionals about the difficulties Black male victims encountered when seeking help. Furthermore, stakeholders, policymakers, academic institutions, and organizations could develop programs tailored to the unique needs of clinicians working with the Black population. Finally, mental health professionals might establish a framework for multicultural counseling to improve the effectiveness of services for Black men who are IPV victims.

Summary

There was an extensive discussion in the literature that depicted Black males as IPV perpetrators. However, there was limited research on formal help-seeking behavior among male victims of IPV. The rising number of Black male victims of IPV presented both opportunities and challenges for mental health providers. Men are generally hesitant to seek help as victims of abuse. Social stigma and societal expectations further complicated the efforts of men to access formal assistance. This study focused on the

lived experiences of clinicians who treated Black male victims of IPV. In Chapter One, I introduced the study, discussed its background, and reviewed existing literature. I highlighted the research gap, outlined the problem statement, and stated the purpose of the study. I also described the nature of the study and the data collection process used to answer the research questions. Additionally, I provided an overview of the theoretical framework grounding the study, along with definitions of key concepts, assumptions, scope, delimitations, limitations, and significance. In Chapter Two, I discuss the literature search strategies, identify the gap in existing research, explain the theoretical framework, and review relevant literature. I conclude Chapter Two with a summary.

Chapter 2: Literature Review

There has been an increase in IPV against men, which is a social issue. The rise in IPV cases among male victims presented opportunities and challenges for mental health providers. Researchers have shown that victims of IPV have sought care from health care providers to treat injuries inflicted by their intimate partners (Nicolaidis & Paranjape, 2009; Xu et al., 2018). In addition to medical services, mental health practitioners are a resource for assisting IPV victims with mental health issues such as anxiety, depression, and PTSD (J.L. Berger et al., 2013; Nicolaidis & Paranjape, 2009). However, studies indicated that men experiencing IPV are often reluctant to seek formal help (Taylor et al., 2022). These reasons include fear of judgment, social stigma, lack of culturally competent care, lack of diversity among counselors and counseling programs, lack of culturally appropriate services, and limited societal awareness (E.A. Bates et al., 2019; Lysova et al., 2020; Roddy, 2013; Taylor et al., 2022; V. Tsui et al., 2010; A. Walker et al., 2020).

Scholars have examined the help-seeking behaviors of Black males, their mental health issues, and psychiatric disorders (Cénat et al., 2024; Fante-Coleman & Jackson-Best, 2020; Shim, 2021). Research showed that Black men often hesitate to seek formal mental health services (Bauer et al., 2022), and barriers such as culturally incompetent care, limited access to culturally appropriate programs, and scarcity of clinical counselors hindered the Black community (E.W. Gandolf, 2008; E.W. Gandolf & Williams, 2001). E.W. Gandolf and Williams (2001) confirmed these issues, noting a high dropout rate

among Black men in conventional treatment. Additionally, E.W. Gandolf (2008) reported that limited access to diverse mental health services impacted formal help-seeking among Black populations. These challenges emphasized the need for clinicians to provide culturally competent care to ethnic minority groups (McLeod et al., 2024; A.L. Reynolds, 2001; A.L. Reynolds & Pope, 1991). The current study aimed to assess clinicians' ability to deliver and incorporate a curriculum focused on multicultural counseling and treatment modalities for Black male victims of IPV. Findings may contribute to the existing literature to address clinicians' cultural competency and how it could potentially generate new insights and improved multicultural treatment approaches for racial groups, particularly Black men.

Literature Search Strategy

A thorough search of peer-reviewed articles was conducted to find reliable studies on clinicians' lived experiences in treating male victims of IPV. However, my search did not identify empirical studies focused on clinicians' experiences with this population. Instead, I found articles that explored the experiences of male IPV victims and their help-seeking behavior. Due to the limited availability of literature addressing clinicians' lived experiences with male IPV victims, I relied on seminal works that significantly influenced the field.

The review was conducted section by section to include articles beyond the five-year limitation. Each generated article was closely read, summarized the main points of findings, strengths, and limitations from the following databases: Scholar Works,

Complementary Index, SAGE Journals, APA PsycINFO, PsycARTICLES, Academic Search Complete, ProQuest Central, Google Scholar, APA Psych article, Criminal Justice database, CINAHL Plus with Full Text, and Cochrane Database of Systematic Reviews, in addition to Google Scholar and the Walden University Center for Research and Quality for reliable and credible articles. Boolean operators “AND” and “OR” were used to narrow the expansion of search terms (Atkinson & Cipriani, 2018).

These specific keywords were used to access relevant articles: *intimate partner violence, domestic violence, partner abuse, intimate partner aggression, male victims, male survivors, female perpetrators, domestic violence, domestic abuse, counselors, therapists, psychologists, psychotherapists, mental health professionals, experiences or attitudes, perceptions, views, help-seeking behaviors, challenges, and barriers to help-seeking.*

Theoretical Foundation

The United States of America (U.S.) is known for its cultural diversity. The opportunities in this country have attracted individuals and families from various cultural, racial, and ethnic backgrounds. Through the migration of immigrants from various countries and the blending of cultures, America is referred to as the melting pot (Leslie et al., 2020). The term “melting pot,” as its name implies, symbolizes the diversity in the United States. However, the ideology of White Euro-ethnocentrism—characterized by an us-against-them mentality—served as the foundation for many systematic discriminations, racist attitudes, prejudices, and cultural stereotypes faced by minorities

(Perreault & Bourhis, 1999). Despite differences in culture, race, gender, and ethnicity, a shared experience among all groups is victimization from IPV (Anyikwa, 2015; Barner & Carney, 2011; WHO, 2017).

The negative experiences of IPV motivate victims to seek both formal and informal help and services (Ansara & Hindin, 2010). Informal help is often provided by untrained individuals such as friends, family, coworkers, and clergy (Satyen et al., 2019). Conversely, formal help services are services offered by trained professionals who possess the necessary knowledge, training, skills, and experience in specific fields or specialties, such as mental health providers, medical staff, health care workers, domestic violence hotlines, law enforcement officers, and others. Researchers noted that IPV victims have accessed both formal and informal services (Ansara & Hindin, 2010; A. Machado et al., 2017).

The services men seek, whether formal or informal, depend on the severity of the abuse and their need for help (Ansara & Hindin, 2010; Dim & Lysova, 2022; A. Machado et al., 2017). A. Lysova and Henson (2023) found that IPV men reported seeking formal help for psychological and emotional support after they had tried informal help. For most IPV male victims, researchers have noted that men often sought informal help from trusted individuals who shared their ethnicity, race, and cultural background (V. Tsui, 2014). Conversely, cultural stigma and attitudes regarding individual culture, race, and ethnicity served as barriers to help-seeking among Black male victims of IPV (A. Robinson-Perez, 2024; Waller, 2022). However, there has been no research on a

comprehensive theory that addresses clinicians' lived experiences in providing multicultural counseling to Black men. To effectively enhance cultural competency among mental health providers, research indicated that this is a multifaceted process. At the individual level, mental health clinicians must continually evaluate their personal and professional biases and prejudices (Sue, 2001). At the academic, organizational, and societal levels, redesigning and implementing training programs that include multicultural counseling and cultural competency is recommended (A.L. Reynolds, 2001; Sue, 2001).

For my dissertation, I aimed to explore the lived experiences of clinicians who treat Black males who have experienced IPV. The study was guided by Sue's (2001) multidimensional cultural competency framework. Sue's model was to understand how different racial and ethnic groups define a helping relationship. Sue examined how race, ethnicity, social class, gender, sexual orientation, and culture influenced human behavior and shaped how individuals act, think, make decisions, and interpret events (Sue, 2001). Sue's model was based on three core dimensions of multicultural counseling that addressed (a) perspectives of specific racial/cultural groups, (b) components of cultural competence, and (c) focal points of cultural competence.

Dimension 1: Race- and Culture-Specific Attributes of Competence

In dimension one, Sue discussed his first tripartite framework of personality identity (Sue, 2001). Personality identity highlights the acknowledgment of the universality of human beings. According to Sue, the biological and physiological

similarities shared by humans formed the foundation for recognizing the existence of other groups, enabling symbols and language to communicate emotions through self-awareness (Sue, 2001). Because these experiences are ingrained in humanity, the shared experiences should outweigh any racial or cultural differences, even though these factors are part of individual identity formation (Sue, 2001).

The second aspect of Sue's tripartite is the group level of personal identity (Sue, 2001). Sue asserted the uniqueness of each person, the culture they are born into, and their social practices, values, and beliefs are attributes of personal identity, which is also subject to scrutiny through the lens of social and political norms and ideology (Sue, 2001). Sue added, at the human continuum, we are continually evaluated by influential cultures and societies whose racial prejudices and biases may shape how other group members perceive themselves.

The final aspect of Sue's tripartite is the development of personal identity, which is the combination of an individual's genetic makeup and personal experiences that are unique to them. According to Sue (2001), although we identify with a larger group and as members of the human race, these attributes—and the understanding that no two people are the same—mean clinicians must recognize each person's individual experiences without linking them solely to their group identity. Failing to incorporate these traits into practice has limited the field of psychology and the ability of mental health professionals to truly understand and recognize the experiences of others, individually and collectively.

Dimension 2: Components of Cultural Competence

The issue of racism is a topic that is ignored by society. According to Sue (2001), it is mainly due to the discomfort of addressing personal and societal assumptions, discrimination, social and professional biases, and individual prejudices given our differences. However, in psychology, where human behavior and conditions are constantly examined, scholars asserted that clinicians' ability to provide multicultural counseling to racially diverse groups requires the awareness of both implicit and explicit cultural assumptions (D.W. Sue et al., 1999, 2024).

The concept of mental health providers working with individuals from diverse racial and ethnic backgrounds originated from the attitudes and beliefs outlined in Sue's three-dimensional model (Sue, 2001). The first component challenged mental health providers to understand the cultural factors that influence personal beliefs, values, and attitudes (Sue, 2001). The second component is the knowledge base, where clinicians are expected to develop an understanding and awareness of the worldviews of culturally diverse individuals and groups (Sue, 2001). The final component is the skills, which ensure that mental health providers apply culturally appropriate interventions and communication methods to meet the needs of culturally diverse populations in practice (Sue, 2001).

Dimension 3: The Foci of Cultural Competence

Cultural competency is primarily discussed at the micro-level (individual), with less emphasis on the macro-level (the profession of psychology, organizations, and

society in general) (J.M. Jones, 1998; Sue, 2001). However, to develop cultural competency at the macro level, it is important to dismantle the ethnocentric standards of practice rooted in White ethnocentrism and adopt a comprehensive approach that involves minority groups at the individual, professional, organizational, and societal levels (Sue, 2001). To become a culturally competent person, Sue emphasized the importance of rejecting inherited prejudices, attitudes, beliefs, personal biases, preconceived notions, assumptions, and any misinformation that sustained injustice against cultural groups (Sue, 2001). Additionally, individuals need to be willing to challenge their own ideologies by immersing themselves in other cultures to understand their ways of life, fears, concerns, and lived experiences (Sue, 2001).

At the professional level, Sue also challenged mental health professionals to shift their perspective on cultural competency from focusing solely on individual and universal levels of identity to adopting a more multicultural treatment approach in practice. This approach required the American Psychological Association of Mental Health Providers to support mental health providers' multicultural treatment approaches without strict adherence to the Ethical Code and Practice Guidelines (Ethical Principles of Psychologists and Code of Conduct, 2002; Sue, 2001). At the organizational level, cultural competency involves operating in a multicultural manner within a pluralistic society rather than adopting a monocultural approach (Sue, 2001). This means that organizations should welcome and respect diversity in the workplace and within their structures to promote growth at the individual, professional, and organizational levels

(Sue, 2001; R.R. Thomas, 1990). Furthermore, Sue (2001) stated that organizations that embrace and value multiculturalism also prioritize equal access and opportunity for their members and clients by fostering diversity and encouraging cultural awareness.

At a societal level, systematic racism in America has hindered the progress of Americans for racial and cultural reconciliation (Sue, 2001). For this reason, President Clinton signed an executive order that created a Race Advisory Board to address racism in America. The order challenged Americans to embrace racial diversity, where no one group dominates another, regardless of race, ethnicity, culture, age, gender, or sexual orientation (Advisory board to the president's initiative on race, 2001; Sue, 2001).

Literature Review Related to Key Variables and/or Concepts

The prevalence of IPV is higher than reported. It is a widespread issue with significant financial costs to society (Sardinha et al., 2022; Spivak et al., 2014; Wilson et al., 2014). Researchers have reported IPV affects both men and women in marriages, cohabiting relationships, and dating relationships (Scott-Storey et al., 2022; Spivak et al., 2014; WHO, 2017). Abuse between intimate partners can be physical, sexual, financial, emotional, and psychological (Saltzman et al., 1999). Scholars have estimated that 27% of women have experienced IPV worldwide (Chemhaka et al., 2023; Sardinha et al., 2022; Satyen et al., 2019; WHO, 2021), and women are the primary victims of IPV (Alhabib et al., 2010; Chemhaka et al., 2023; Satyen et al., 2019; WHO, 2010, 2021). However, research has shown men experience IPV at a similar rate as women (Lysova et al., 2020). Data from the National Intimate Partner and Sexual Violence Survey indicated

that in the United States, over one-third of women (35.6%) and more than one-quarter of men (28.5%) have experienced rape, physical violence, and stalking by an intimate partner in their lifetime (Niolon et al., 2023; 2021; Frieden et al., 2011; J.A. Smith, 2017). Scholars have linked certain characteristics of IPV against men and women to poor mental, physical, psychological, and social health (J.C. Campbell, 2002; A.L. Coker et al., 2021).

Studies indicated that the lifetime prevalence of IPV among men ranges from 8% to 23%, with psychological abuse being the most common at 17.3% (A.L. Coker et al., 2021; P. Tjaden & Thoennes, 1998). A similar report showed that 47% of men who experienced psychological abuse sought professional help (Novotny, 2006). Other researchers argued that men are the least likely to pursue mental health services (Bates, 2020a; Ogbe et al., 2020). However, difficulty in recognizing the negative consequences of abusive relationships was a known concern for men (A.L. Coker et al., 2002; A.L. Coker et al., 2021). Research on male IPV victims has found that men experience symptoms of depression, anxiety, and PTSD, and are at higher risk for substance use disorder as well as suicidal thoughts and attempts (Clare et al., 2021; Spencer et al., 2022). Men's limited ability to recognize abuse in IPV led to low help-seeking behavior (Howard et al., 2010; A. Machado et al., 2020). However, men who sought help were often faced with significant challenges and barriers (Bates, 2020a, 2020b).

Scholars have shown that men experiencing IPV are disproportionately underrepresented in accessing services and resources available to women experiencing

IPV (Dim & Lysova, 2022; McCormack & Hirschel, 2021; Stanziani et al., 2019; P.A. Thomas & Hart, 2023). These services and resources include community resources, domestic violence programs, shelters, healthcare, and mental health services (Coney & Mackey, 1999; Schechter, 1982; Wolf et al., 2003). Despite men's limited access to these resources, accessing mental health services remained an important part of supporting IPV victims (A.L. Coker et al., 2021; V. Tsui et al., 2010). The professional services provided by mental health clinicians are essential for gaining an insight into and understanding the personal experiences of men facing IPV (K.F. Hogan et al., 2021; L. Tarzia et al., 2020; Tutty et al., 2020). However, frustration with accessing culturally appropriate services and resources has been reported as a barrier (Betz & Fitzgerald, 1993; E.W. Gandolf, 2008; E.W. Gandolf & Williams, 2001). Building on the existing literature, this study aimed to explore the lived experiences of clinicians who treat Black males who have experienced IPV.

Intimate Partner Violence

IPV has been a topic of discussion among scholars for many years (Dobash & Dobash, 2004; M.P. Johnson, 2006; Martin, 1976; P. Tjaden & Thoennes, 2000). During the 1970s, the term 'wife battering' was adopted by the feminist movement to highlight the prevalence of violence against women by their husbands and challenge the patriarchal structure (Martinez, 2011; Martin, 1976). However, the increasing body of research has shown that men are also victims of IPV (Bates, 2020a, 2020b; Carmo et al., 2011; Corbally, 2015; A. Machado et al., 2020). The existing research, conducted by these

bodies, has mainly investigated the effects of IPV on European American men (Chang et al., 2009; Koss & Hoffman, 2012; Murray, 1999), with limited research on the experiences of Black male IPV victims. However, as new research emerged on male victimization in intimate partner relationships, there has been a shift from a purely feminist perspective to a broader view of IPV that includes both men and women (Randle & Graham, 2011).

Research suggested that, despite the paradigm shift, men are oppressed in society as IPV victims (Crann & Barata, 2021), and the type of services provided to men depended on how an individual or organization defined abuse in IPV relationships (Nicolaidis & Paranjape, 2009). For example, a criminologist who operates from an objective standpoint may look for physical evidence of an assault and rely less on emotional or psychological aspects of the abuse (Kilpatrick, 2004; Nicolaidis & Paranjape, 2009). In contrast, a public health survey may focus on the psychological and emotional impacts experienced by IPV victims (Nicolaidis & Paranjape, 2009), whereas a health care provider may rely more on physical evidence rather than psychological or emotional signs (Alpert et al., 1998; Nicolaidis & Paranjape, 2009). Given the differences in how a profession or organization defines IPV, Ali et al. (2016) asserted that the perceived definition of IPV can influence whether a professional sees their role as limited to treating physical injuries or as a broader responsibility that requires connecting survivors to trauma-related resources and counseling. In the mental health field, the literature indicated that clinicians' backgrounds, experiences, training, political beliefs,

and research methods influenced their approach to treatment (Ali et al., 2016). However, for clinicians working within established boundaries, the American Psychological Association Practice Guidelines (APA, 2017) function as a key resource for mental health treatment information among practitioners. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013) is the nationally recognized diagnostic tool used by mental health providers for clinical diagnosis (First et al., 2021). Within DSM-5, clinical diagnoses of various mental illnesses are listed (e.g., anxiety, depression, PTSD, etc.). However, no criterion for IPV was found. Therefore, mental health providers relied on their training, experience, knowledge, and skills to assess victims of IPV in clinical practice (Nicolaidis & Paranjape, 2009). Nonetheless, the need for clinicians to follow APA guidelines limits their ability to creatively apply their skills, experiences, and knowledge outside the DSM-5 (Halfond et al., 2021; Nicolaidis & Paranjape, 2009).

A quantitative study examined the quality of patient-rated therapeutic working alliance with a counselor in both Cognitive Behavioral Analysis System of Psychotherapy (CBASP) and Brief Supportive Psychotherapy (BSP) (Arnow et al., 2013). The study's results showed that an early working alliance was positively associated with a lower subsequent rating of depressive symptoms in both the CBASP and BSP (Arnow et al., 2013). In the same study, Arnow et al.'s reported that participants experienced improvement in depressive symptoms through a combination of medication management and forming therapeutic alliances with psychotherapists. In a similar study, Klein et al. (2003) found that patients receiving a combination treatment of CBASP and

psychiatric medication had stronger alliances with their psychotherapists than patients receiving CBASP alone. The results of these studies highlighted the importance of combining prescribed medication with a therapeutic alliance in clinical counseling outcomes. There was limited data on how clinicians' years of experience in clinical practice affected treatment outcomes.

Abused Typology

The types of abuse experienced by men are differentiated in many forms. As mental health professionals, understanding these different forms of abuse is essential to improving victims' outcomes. The discussion of various abuse types and violence typologies has been explored in research (M.P. Johnson, 2006; M.A. Straus, 2008; WHO, 2010). However, M.P. Johnson's work on violence typologies has been prominent in the literature, helping to explain IPV (Gulliver & Fanslow, 2015; Nyberg et al., 2016). A body of scholars that studied IPV asserted that IPV is bidirectional violence carried out by men and women (M.P. Johnson, 1995; M.A. Straus & Smith, 2017). Others viewed IPV as gender-specific violence committed by men against women (A.M. Brown & Ismail, 2019; Browne, 1993). Despite differences between perspectives among scholars, M.P. Johnson's work clarified men's experiences of IPV (M.P. Johnson, 1995, 2006).

Research has shown that in family violence, most conflicts start as minor arguments or disagreements that may escalate into more serious forms of violence (Carlson & Dayle, 2010; A.S. Jones et al., 2010). However, family violence is not solely about patriarchal control; it is a conflict equally perpetrated by men and women in

intimate relationships (Archer, 2000; M.A. Straus, 1980). Using the Conflict Tactic Scale to measure the rate of IPV in intimate relationships, researchers found that men and women use violence at similar rates (Ackerman, 2018; Brinkerhoff & Lupri, 1988; Morse, 1995), with some studies showing that women use violence at even higher rates than men (Ackerman, 2018; Headey et al., 1999). Therefore, understanding the different types of abuse and the extent to which both men and women experience IPV is vitally important in recognizing the various forms of IPV and the effects of violence on victims.

A meta-analysis study examined physical aggression research on consequences in heterosexual relationships and found that women were slightly more likely. ($d = -.05$) than men to use one or more acts of physical aggression more frequently than their male partners (Archer, 2000). However, men were more likely ($d = .15$) to inflict an injury, and overall, 62% of those injuries inflicted were by female partners (Archer, 2000). Further, in family violence, an act of physical aggression was equally reported, although a higher proportion of women than men reported being injured by their partner (Dutton & Nicholls, 2005).

Situational Couple Violence

Situational Couple Violence (SCV) is the most common type of violence committed by both men and women in heterosexual, cohabiting, and dating relationships (Archer, 2000; Kelly & Johnson, 2008). Generally, an act of SCV is not intended to gain control over another partner (Kelly & Johnson, 2008). Instead, researchers described SCV as stemming from situations or arguments that can escalate into physical violence

due to both partners' inability to manage or resolve conflicts (Kelly & Johnson, 2008; Kwong et al., 1999; M.A. Straus, 2008). Consequently, unresolved conflicts in SCV could result in severe forms of violence (M.P. Johnson, 1995; Kwong et al., 1999). Nielsen et al. (2016) reported that the most common form of SCV is physical aggression.

A qualitative study on men's experiences in SCV found that men were physically abused by their intimate partners, including being grabbed, shoved, scratched, bitten, kicked, and hit (Brooks et al., 2020; Carmo et al., 2011; D.A. Hines & Douglas, 2016; M.P. Johnson, 2006). A mixed-methods study combining quantitative and qualitative approaches on Chinese women's mental health as victims of Intimate Terrorism (IT) and SVC found that Chinese women experienced more mental health issues (e.g., depression and PTSD) and had a higher rate of medical problems from physical injuries in IT relationships. In contrast, women in SVC within IPV relationships reported fears of their male partners (Tiwari et al., 2015).

Coercive Controlling Violence

Coercive controlling violence (CCV) or IT is violence observed in institutions, businesses, and agencies (Kelly & Johnson, 2008). However, victims of IPV have reported CCV in intimate relationships (E.A. Bates et al., 2019; Scott-Storey et al., 2022; Tiwari et al., 2015). In IPV relationships, research reported perpetrators use tactics such as manipulation, intimidation, isolation, denial, blaming, coercion, and threats to gain control and power over their victims (Hamberger et al., 2017). Beyond the overall violence experienced by victims in CCV relationships, scholars have found that

psychological abuse has the most severe negative effects on IPV victims (M.P. Johnson, 1995; Kelly & Johnson, 2008; Tiwari et al., 2015). Tiwari et al. (2015) supported this view, showing that Chinese women who experienced CCV faced significant mental health issues compared to those who experienced SCV.

A qualitative study on men's experiences in IPV relationships reported psychological abuse by their female partners (E.A. Bates et al., 2019; Bates, 2020a; Brooks et al., 2020; Scott-Storey et al., 2022). Men often described feeling socially and emotionally isolated from their children, family, and friends (Walklate & Fitz-Gibbon, 2019). Similarly, others reported a negative impact on their self-esteem and self-worth (Richardson & Kloess, 2022; Robertson & Murachver, 2011). Researchers highlighted abuse of legal administrative power as another form of CCV (H. Douglas, 2018; Walklate & Fitz-Gibbon, 2019). Studies showed that within the criminal justice system, the use of coercive control in expert testimony during court proceedings served as the basis for homicidal cases as self-defense against male partners (Fadina et al., 2019; Walklate & Fitz-Gibbon, 2019). Moreover, men who sought help through the criminal and judicial systems reported abuse of legal and administrative power (D.A. Hines & Douglas, 2018). Within the criminal justice system, researchers identified cases where men who sought help from law enforcement officers were arrested, while their claims as victims of IPV were dismissed (Backes et al., 2020; Bachman & Coker, 1995; R. Brown & Frank, 2006). Within the judicial system, the abuse of administrative power was a prominent concern

raised by men when the system favored women in custody hearings (A. Walker et al., 2020; Walklate & Fitz-Gibbon, 2019; Wangmann, 2008).

Violence Resistance

Violence Resistance (VR) is a tactical strategy used by non-violent individuals to de-escalate an attack from a violent person (M.P. Johnson, 1995). Studies reported that victims of abuse typically employed this type of force to avoid conflict or self-defense (M.P. Johnson, 1995; Kelly & Johnson, 2008). The literature indicated that women primarily use VR against their male partners in IPV relationships (Crossman, 2016). However, other researchers argued that men have used VR to de-escalate physical conflicts with their female offenders (E. Douglas & Hines, 2011; A. Machado et al., 2018).

Mutual Violence Control

M.E. Johnson (2008) asserted that MVC is not gender symmetric. However, it is the least studied type of abuse. MVC involves violence reciprocally perpetrated by both partners to gain control over each other (Ferraro, 2012). D.A. Hines and Douglas's (2018) quantitative study examined the frequency and severity of various forms of partner violence, as well as the relationship between health and mental health among men who (a) experienced IT versus SCV and (b) men who experienced IT versus MVC. The study's results indicated that MVC caused the most injury and mental health problems in relationships characterized by bidirectional violence compared to IT/SVC.

Physical Abuse

Physical violence involves inflicting pain or injury on another person with the intention of causing physical harm, pain, or suffering (WHO, 2017). In intimate relationships, both men and women experience physical violence (Ali et al., 2016; Desmarais et al., 2012), in which men sought medical treatment for injuries caused by female offenders (Basile et al., 2011). In contrast to physical injuries, emotional abuse was also reported to be prevalent. Wangmann (2008) described men's experiences of being slapped, beaten, kicked, pinched, bitten, pushed, shoved, dragged, and hit with objects by female partners. Catalano and Statistician (2013) conducted a comparative study to evaluate medical treatment provided to both female and male victims of IPV from 2002 to 2011. The results showed that 18% of female victims received medical services compared to 11% of male victims (Catalano & Statistician, 2013). In addition to health care services, men reported experiencing revictimization when their experiences as IPV victims were discredited by health care providers (McCaw et al., 2001; Ramsay et al., 2012). Furthermore, a data report from 2002-2011 by the U.S. Department of Justice's Bureau indicated that 44% of men in IPV relationships sustained physical injuries, including gunshot wounds and knife-related injuries, while 41% of injuries resulted in bruises and cuts (Catalano & Statistician, 2013).

Emotional and Psychological Abuse

Psychological violence involves using behaviors aimed at humiliating and controlling another person, whether in public or private (Ali et al., 2016). In addition to

the challenges that exist within society, accepting the act of violence toward men in IPV, researchers have explored the psychological and emotional impacts on abused men (Bates, 2020a, 2020b; Brooks et al., 2020; Carmo et al., 2011; A. Machado et al., 2018). Findings from research studies indicated that psychological abuse was the most common form of abuse experienced by men in IPV relationships (Hine et al., 2022; D.A. Hines & Douglas, 2011; K.F. Hogan et al., 2012; Mejia, 2005). Multiple studies reported that female perpetrators used various tactics to inflict psychological and emotional pain to gain control over their male partners (Kolbe & Büttner, 2020). Researchers examined psychological tactics against men and found that female offenders sometimes posed as victims to law enforcement during domestic violence calls to inflict psychological harm on male victims (E.A. Bates et al., 2019; E. Douglas & Hines, 2011; D.A. Hines et al., 2015; A. Machado et al., 2018).

Furthermore, studies on psychological and emotional abuse of men in IPV relationships have shown that men experience such abuse from their female partners through various forms of humiliation (Dim & Lysova, 2022; A. Machado et al., 2018; V. Tsui, 2014). Thus, men have been humiliated through acts like insulting, belittling, yelling, controlling, isolating from family and friends, stalking, denying access to children, and making false, accusatory claims of child abuse (E.A. Bates et al., 2019; Bates, 2020a; Chen et al., 2020; A.L. Coker et al., 2021; Dim & Lysova, 2022; J. Eckstein, 2016). Furthermore, psychiatric disorders have been linked directly to psychological abuse impacting men's mental health (A.L. Coker et al., 2021; M.

Próspero, 2007; M. Próspero & Fawson, 2010). Compared to the general public, male victims of IPV reported significant mental health issues, including anxiety, depression, chronic pain, PTSD, substance abuse, alcohol misuse, and suicidal thoughts and attempts (J.C. Campbell et al., 2000; Government Accounting Office, 2020; D.A. Hines & Douglas, 2010, 2015; Kwako et al., 2011; Richardson & Kloess, 2022; B. Russell et al., 2015).

Financial/Economic Abuse

Victims of IPV have reported experiencing economic and financial abuse by their partners (L. Johnson et al., 2022; Kutin et al., 2017). Economic abuse involves a deliberate attempt to control a partner's ability to acquire, use, and retain economic resources and security, thereby hindering individual potential for self-sufficiency (Adams et al., 2008). Similarly, financial abuse is a purposeful effort to control a partner's finances by denying access to restrict their livelihood (Sharp-Jeffs, 2015). In an IPV relationship, economic abuse is evident when the perpetrator uses control to exploit or sabotage their partner's economic resources (Postmus et al., 2015). Most scholars agree that financial and economic abuse against women is widespread (Adam et al., 2008; Antia et al., 2014; Awwad et al., 2014). However, financial and economic abuse against men in IPV also significantly affects men's financial and economic well-being (Outlaw, 2009; Poole & Rietschlin, 2012).

Adam et al. (2008) studied women's experiences of financial and economic abuse by men and found that men often denied women the ability to gain economic security in

intimate relationships. Furthermore, men interfered with women's efforts to find employment, restricted their access, and had limited access to household resources, bank accounts, and financial information (Adam et al., 2008; Awwad et al., 2014; Haj-Yahia, 2000). While researchers' findings supported economic and financial abuse of female victims of IPV, many also reported that such abuse is perpetrated against men by female partners in IPV relationships with some suggesting that women are as likely or more likely to perpetrate than men, depending on the type of violence measured (Fulu et al., 2013; A.D. Garza et al., 2020, 2022; Kutin et al., 2017; Outlaw, 2009; Poole & Rietschlin, 2012; Postmus et al., 2015; Stylianou, 2017; V. Tsui, 2014; J. Walker et al., 2018; A. Walker et al., 2020). Victims of IPV have reported experiencing economic and financial abuse by their partners (L. Johnson et al., 2022; Kutin et al., 2017). In contrast, men often accumulated debt in their female partners' names, creating financial burdens (Adam et al., 2008).

Sexual Abuse

Sexual violence or sexual abuse refers to any sexual act directed at another person without their consent (Hedjazi et al., 2022; WHO, 2010). This form of violence can take many shapes. In the context of IPV, sexual abuse involves coercing or forcing a partner to perform sexual acts against their will (Mitchell & Raghavan, 2021). Research has shown that both women and men face sexual abuse in intimate relationships (Fawole et al., 2021; Hedjazi et al., 2022). Most studies have mainly focused on sexual violence against women (M.E. Bagwell-Gray et al., 2015, 2021; DiMauro & Renshaw, 2021; L.

Tarzia, 2021). This focus has overshadowed men's experiences with sexual victimization. According to U.S. research, one in four men has experienced sexual violence from an intimate partner at some point in their lives (Niolon et al., 2023).

According to a U.S. Department of Justice's Bureau of Justice Statistics report, female partners were the perpetrators in 39% of serious violent crimes against male victims of intimate partner violence (IPV) between 2002 and 2011 (Catalano & Statistician, 2013). Of that violence, 22% was aggravated assault, 16% involved robbery, and 1% was classified as rape and sexual assault (Catalano & Statistician, 2013). The underreporting of abuse by men led scholars to question the accuracy of the 1% figure, noting that men often do not report all sexual violence (Abraham et al., 2004; Brooks et al., 2020; Scott-Storey et al., 2022). Khalifen et al. (2015) conducted a quantitative study on domestic and sexual violence among men and women with severe mental illness. Khalifen et al.'s found that only 43% of participants reported sexual abuse to a psychiatrist after a year of intensive treatment. The literature highlighted that IPV victims are often overlooked in health care settings for various reasons. Sugg (1999) explained that the lack of professional training in identifying abuse was a primary reason why IPV victims were overlooked. Additionally, the discomfort associated with addressing abuse and opening the "Pandora's Box" of domestic violence and IPV explained hesitancy among health care providers (Sugg, 1999). Finally, limited time with patients often led health care providers to avoid discussing abuse and IPV with patients (Gutmanis et al., 2007; J. Lavis et al., 2005; Sugg, 1999; teKolstee et al., 2004).

Social Support and Racial Disparities

Research indicated that individuals from diverse racial, cultural, and ethnic backgrounds are affected by IPV (WHO, 2010). Despite individual differences, surviving as victims of IPV in intimate relationships depends on the availability of services and social support. Scholars have examined how social support influences the impact on victims of IPV in seeking formal help (Cho et al., 2020; Potter & Thomas, 2012; Voith et al., 2022). Researchers highlighted the disparity in social support access, noting that Black victims face significant systemic barriers compared to their White counterparts (J.C. Campbell et al., 2000; E.W. Gandolf & Williams, 2001; McCormack & Hirschel, 2021). Studies on arrest rates among racial groups have shown Black offenders are about 39% more likely to be arrested than White offenders, and Black males are 1.6 times more likely to be arrested than Hispanic males at 1.25 (McCormack & Hirschel, 2021). Data from the National Crime Victimization Survey reported that Blacks have the highest IPV arrest rates compared to other racial groups (Beck, 2021; Reiss & Black, 1967), and Blacks are twice as likely to be arrested in IPV-related cases (Anyikwa, 2015; McCloskey et al., 2006).

The arrest rate of Black men in IPV affects help-seeking behavior. Several scholars have examined the social injustice faced by interracial couples both in society and within the criminal justice system (Newbeck, 2005; Potter & Thomas, 2012). The controversy surrounding interracial marriage has a long history. Records indicated that the first interracial union between a White man and a Black woman took place in 1967

(Newbeck, 2005). Richard Perry, a White man, and Mildred Delores Jeter Loving, a colored woman, married in 1967. According to Newbeck (2005), the Lovings faced many challenges, not only from the spectacle of the public for their interracial marriage but also within the criminal and judicial systems. Despite the opposition against Richard Perry and Mildred Delores Jeter Loving's union, the couple, who faced persecution, challenged Virginia's law prohibiting interracial marriage. The Supreme Court ruled in favor of the Lovings in *Loving v. Virginia* (Newbeck, 2005). This ruling established the foundation for interracial marriages. However, despite the progress made in the ruling of the Lovings v. Virginia, barriers to equality and social justice for interracial marriages are scrutinized under societal ideologies.

Potter and Thomas (2012) conducted a semistructured qualitative study to examine the experiences of White women married to Black men in an IPV relationship. In this research, Potter and Thomas aimed to explore the responses from the victim's family, friends, the public, social and medical services, and members of the criminal justice system. The study's findings revealed that the issue of abuse was not considered a concern. However, the abuse was justified when the White woman was blamed for the interracial marriage (Potter & Thomas, 2012). The results from this study showed that social stigma and racial stereotypes have portrayed Black men as violent and as abusers (Potter & Thomas, 2012).

Furthermore, racial discrimination within the legal system has been a concern. Scholars who studied law enforcement responses and arrest rates of Black men in

interracial and intra-racial IPV relationships found that Black men had the highest arrest rates within the criminal justice system (E.A. Bates et al., 2019; Bates, 2020a, 2020b ; Dichter et al., 2011; Dim & Lysova, 2022; S. Lipsky et al., 2012). McCormack and Hirschel (2021) examined police responses to IPV in relationships of different races. McCormack and Hirschel discovered that in IPV cases where the victim and offender were of the same race (Black male and Black female), police intervention was often inadequate. However, in interracial relationships where the offender was a Black male and the victim was a White female, the likelihood of arrest was greater for the Black male than for the White female offender (Lantz et al., 2023). Additionally, in incidents where the offender was a White male and the victim was a Black female, the White male was disproportionately less likely to be arrested (S. Lipsky et al., 2012). In contrast, a Black woman who committed an offense against a White man was more likely to be taken into custody (Ahmadabadi et al., 2017; Beck, 2021; R. Brown & Frank, 2006; Fusco, 2010; K. Henning et al., 2006; D.A. Jones & Belknap, 1999; Lytle, 2014).

Barriers to Help Seeking

A body of research has shown that men's ambivalence toward seeking formal help was prevalent. Researchers suggested the ambivalence stemmed from social norms and ideologies related to traditional masculinity (A.M. Brown & Ismail, 2019; R. W. Connell & Messerschmidt, 2005; A. Lysova et al., 2020; M. A. Straus, 2008). Men who are perceived as weak have often been the barrier to leaving an abusive relationship, despite the negative consequences (R. Connell, 1995; R.W. Connell & Messerschmidt, 2005; S.

Eckstein, 2009; J. Eckstein, 2010, 2016). According to D.E. Reidy et al. (2009). The conflict between the traditional male gender role expectations and other social influences pressured men to prove their masculinity. Traditional masculine socialization emphasized qualities such as strength, toughness, and independence (R.W. Connell & Messerschmidt, 2005). As a result, adhering to these beliefs discouraged men from seeking formal help.

Another factor that discouraged men from seeking help as victims of IPV is the lack of accessible programs and resources designated for them. Findings from qualitative research suggested that access to domestic shelters and domestic violence programs, which were often available to female victims, resulted in male victims being denied access to these resources (McNeely et al., 2001; Migliaccio, 2001; V. Tsui et al., 2010, V. 2014; A. Walker et al., 2020). Researchers indicated that men faced several challenges when attempting to seek formal help; and those who sought help risk being ridiculed, mocked, humiliated, ostracized, and an attack on masculinity (Brooks et al., 2020; E. Douglas & Hines, 2011; Hine et al., 2022; Kulkarni, 2021; Kunkel & Neilsen, 1998; National Network to End Domestic Violence, 2021; Robinson et al., 2021; V. Tsu et al., 2010).

Additionally, men's fear of shaming, embarrassment, humiliation, and mistrust within systems and service providers affected their willingness to seek help (E.A. Bates et al., 2019; A. Machado et al., 2016, 2020; V. Tsui et al., 2010). Several scholars found that men who contacted law enforcement for support and intervention were often arrested (Dim & Lysova, 2022; Lippy et al., 2020; Lockwood & Prohaska, 2015; B. Russell et al.,

2015; B. Russell & Kraus, 2016). In family and civil court, men's need for protective orders against their female offenders was minimized, ignored, overlooked, or denied (Muller et al., 2009). Those who were awarded such orders experienced the failure of the criminal justice system to enforce them when violated (Herrera & Amor, 2024; Mele et al., 2011; Melton & Nordmeyer, 2014).

Clinicians and Intimate Partner Violence

The social influences of mental illness and its associated stigma impact an individual's decision to seek formal help. For Black male victims of IPV, these decisions are shaped by many factors. Systemic racism, discrimination, stereotypes about their culture, and mistrust of the system hindered efforts to seek formal help (Banks, 1999; Mosley et al., 2021). Research has shown that a Black man's decision to seek help indicated a need for professional intervention. E.W. Gandolf and Williams (2001) studied the treatment outcomes of minorities in conventional counseling. E.W. Gandolf and Williams found that there was a high dropout rate and treatment failure when Blacks were placed in conventional counseling. Treatment failure, as defined by many scholars, is characterized by the client's lack of response to treatment outcomes or failure to exhibit signs of improvement (Askeland & Heir, 2013; M.J. Lambert, 2013, 2017; von der Lippe et al., 2008). In contrast, therapeutic counseling aimed to promote the positive well-being and growth of those in distress (Simms, 2017).

Because mental health providers play a critical role in counseling male IPV victims, few studies have examined the experiences of mental health providers as service

providers (Xu et al., 2018; Yarrow & Churchill, 2009). Among these researchers, scholars suggested that clinicians' understanding of IPV could facilitate a more nuanced view of the relationship between IPV and mental health symptoms (Foran et al., 2015; Oram et al., 2022; Trabold et al., 2020). Therefore, clinicians having a better understanding of the connection between IPV and mental health issues could enhance assessment, treatment planning, and appropriate referrals (APA, 2013; Burns et al., 2022; Ogbe et al., 2020). However, despite these potential benefits, the rate at which clinicians assessed and identified IPV remains low (Howard et al., 2010). Howard et al. reviewed the effectiveness and frequency of mental health providers' screening for domestic violence and found that mental health providers often did not ask about domestic violence when conducting assessments.

In contrast, Forsdike et al. (2019) found a significant correlation between a psychiatrist's knowledge, comfort, and readiness to manage domestic violence and the increased hours spent on domestic violence training. Xu et al.'s (2018) study found that with adequate training, health care providers were better equipped to handle mental health issues and made appropriate referrals for collaborative care with mental health providers. Research indicated that with proper training, mental health providers can improve their knowledge to increase confidence in helping victims of domestic abuse (Howard et al., 2010). Doyle et al. (2022) qualitatively analyzed male victims of IPV experiences and found that male IPV victims' interactions with therapists were ineffective. McKenzie et al. (2022) review of the literature showed that stigma against men's mental health

contributed to their ambivalence in seeking formal help. Furthermore, Lømo et al. (2021) study found that clients often experienced treatment failure when clinicians were perceived as inflexible, detached, lacking transparency, disrespectful of confidentiality, and unable to perform thorough assessments or show genuine understanding. Conversely, Hardin and Fox (2015) found that working with a therapist was easier for some men to address mental health issues when help-seeking stigma was normalized. Howard et al. (2010) concluded that mental health providers are a crucial part of changing the direction and reducing the stigma related to mental health services for abuse victims. Kennedy et al. (2024) discovered that men's distrust of therapy and therapists influenced their willingness to seek help. Some research suggested that men's inherently vulnerable nature in therapy clashes with traditional masculine norms that emphasize self-reliance, stoicism, and emotional restraint. Therefore, men's low expectation of the benefits of psychotherapy contributed to their reluctance to pursue formal help (E.W. Gandolf & Williams, 2001; Kennedy et al., 2024).

Summary and Conclusion

In summary, numerous researchers have investigated the help-seeking behaviors of IPV victims and the challenges and barriers they have encountered (Bates, 2020a, 2020b; Kim et al., 2024; Dim & Lysova, 2022; Taylor et al., 2022; A. Walker et al., 2020). However, most of this research has primarily focused on female victims (Ahmadabadi et al., 2017; Alhabib et al., 2010; Anyikwa, 2015). The lack of public awareness about men's experiences as IPV victims impacts help-seeking. The existing

literature has highlighted stigmas linked to being a male IPV victim (Bates, 2020a, 2020b; Hine et al., 2022; Scott-Storey et al., 2022). The stigma that IPV was male-perpetrated violence influenced individuals' decisions to seek formal help.

For Black male victims of IPV, social constructs associated with race significantly influenced treatment outcomes in traditional counseling programs (E.W. Gandolf & Williams, 2001). Research has shown that systematic racism, racial discrimination, and a misunderstanding of Black men's experiences served as barriers to mental health services (Banks, 1999; Mosley et al., 2021). To better understand these hindrances, researchers identified factors that could improve professional services for Black men. Sue (2001) proposed that to ensure equitable and effective services, mental health providers should deliver culturally responsive care that values all aspects of a client's identity, background, and experiences. E.W. Gandolf and Williams (2001) found that perceptions of Black men leading to treatment dropout were linked to the lack of culturally focused counseling programs. The existing literature offered valuable insights into the various factors that hindered formal help-seeking among IPV male victims. However, a significant gap in the literature exists regarding clinicians' lived experiences in treating Black men who have experienced intimate partner violence (IPV); thus, this study was undertaken to fill the gap.

Chapter 3: Methodology

IPV is a public health issue affecting men and women. Schafer et al.'s (1998) research on IPV rates among married and cohabiting couples in the United States showed male-female partner violence at 5.21% and 13.61%, and female-male partner violence at 6.22% and 18.21%. Despite the prevalence, IPV causes a wide range of physical, emotional, psychological, sexual, and mental health problems for both male and female victims (A.L. Coker, 2021; M. Próspero & Fawson, 2010). However, most research has historically centered on help-seeking of female IPV victims; no studies were found on mental health services for Black men IPV victims. Hence, the support provided by mental health professionals is vital for Black men who seek formal support from mental health providers. At the time of the current study, no empirical research was found that had explored clinicians' lived experiences treating Black male IPV victims. This is the gap in research that I explored.

Research Design and Rationale

This qualitative study was conducted to explore the lived experiences of clinicians who treat Black males who have experienced IPV. Given that clinicians play a pivotal role as service providers to victims of IPV, this study focused on gaining a deeper understanding of their lived experiences. The availability of multicultural counseling and treatment approaches, along with access to culturally appropriate services, programs, and resources, significantly impacts formal help-seeking behaviors among Black men.

Research Question

Based on the identified problem, the research question was the following: What are the lived experiences of clinicians who treat Black males who have experienced IPV? This study aimed to understand clinicians' lived experiences and the challenges they encounter when treating this population. Clinicians included mental health providers who had worked with or provided services to Black male victims of IPV. These professionals included social workers, licensed therapists, mental health nurse practitioners, psychologists, and psychiatrists practicing in the United States. The vital role of these service providers for IPV victims made exploring their lived experiences important to generate new insights and a deeper understanding to help improve formal help-seeking among Black men.

To establish knowledge about the proposed phenomenon, I used interpretative phenomenological analysis (IPA) as the research method for this qualitative study. According to J. A. Smith (2017), phenomenology provides an understanding of others' experiences related to a specific phenomenon. Phenomenological research emphasizes the wholeness of an experience rather than its objective parts (Moustakas, 1994). By focusing on wholeness, the researcher gathers a description from first-person experiences to explain a phenomenon (Moustakas, 1994).

To explore clinicians' experiences and perspectives as service providers for Black male victims of IPV, I employed a qualitative approach. The proposed study employed IPA, a qualitative methodology particularly useful for exploring complex, sensitive, and

emotionally laden topics. This approach was crucial for gaining an in-depth understanding of the unique ways clinicians perceived and made sense of their lived experiences and interactions with Black male IPV victims in treatment. By utilizing an interpretative, idiographic approach, the study captured rich, nuanced data free from the constraints of pre-existing theoretical assumptions, ensuring that participant voices remained central to the analysis.

Qualitative Research Tradition

The phenomenological design was employed to ensure alignment between the research inquiry and the methodology used to capture the essence of participants' experiences. However, it should be noted that case studies, narratives, grounded theory, and ethnography were not chosen for these reasons. The case study method involved a comprehensive analysis of multiple data sources, including direct observation, documents, and artifacts (Ravitch & Carl, 2019). The narrative approach was not appropriate for my study because it focused on the chronological order of events, which is not the goal of this study (Rosiek & Snyder, 2020). The qualitative approach of grounded theory aimed to develop new theories and concepts through systematic data collection and analysis to generate new theories (Tenney et al., 2017). Since this was not the focus of my study, it was not selected. Finally, ethnography was not chosen because this approach focuses on identifying shared experiences within a cultural group or social inquiries, rather than individual experiences (Ravitch & Carl, 2019).

Role of the Researcher

In a qualitative study, the researcher is the primary instrument facilitating the research (Pietkiewicz & Smith, 2014). As the researcher, I recruited participants, collected data, and ensured the study's credibility and trustworthiness. I also conducted semistructured interviews and asked open-ended questions to gather in-depth, rich data on participants' experiences. I built trust with participants and assured them their experiences contributed to an initial study and research on a critical subject. I emphasized to participants that their experiences hold significant value for promoting a potential social change within clinical counseling.

Furthermore, to maintain the integrity, confidentiality, and anonymity of the data and to reduce power imbalances, I informed participants that all research data and information would be protected and kept secure (Rubin & Rubin, 2012). I also addressed research confirmation bias, positionality, and reflexivity. Confirmation bias occurs when researchers seek out information that supports their existing beliefs and overlook data that contradicts them (Nickerson, 1998). I managed confirmation biases through bracketing to identify any biased inputs and opinions (Dörfler & Stierand, 2021). Research positionality refers to the stance the researcher adopts in the study. Olukotun et al. (2021) stated that research positionality refers to the worldview and perspective taken by the researcher. Recognizing the researcher's positionality was important for me because it could affect the researcher's approach regarding the participants, the method used, the content, process, and the results of the study (Holmes, 2020). In this study, I employed a

positionality that was not affiliated with the research participants to prevent potential influence on my interactions with participants and on my thought process, which could impact the data (Ravitch & Carl, 2019).

Reflexivity in research requires the researcher to reflect on thoughts, biases, ideas, emotions, judgments, preconceived notions, and assumptions throughout the study (Soedirgo & Glass, 2020). Howell (2013) stated that reflexivity requires the researcher to make the object of inquiry, constantly questioning how their own worldview and biases are reflected in the research process and outcomes. To practice reflexivity, I kept a journal to record my thoughts, ideas, and insights. I also maintained an objective perspective, free of personal bias and opinion. I used bracketing to capture any assumptions related to participants' race, age, gender, and ethnicity, as well as any pre-existing knowledge (e.g., cultural biases), and observations made before and during the research (Charron & Singh, 2022; Dörfler & Stierand, 2021). Additionally, I adhered to ethical principles. I maintained no personal or professional relationships between research participants (APA, 2017). However, my interest in this study as a Black mental health nurse practitioner stemmed from an awareness of the challenges Black men face in accessing culturally appropriate mental health services as victims and perpetrators of IPV.

The disparities in multicultural counseling within the mental health profession prompted the exploration of clinicians' experiences with Black male IPV victims.

Although exploring this topic could have been sensitive, participants did not express any

feelings of intimidation or powerlessness in their responses to the research questions. The interviews were conducted in a comfortable, friendly, and professional environment. I maintained confidentiality regarding the information shared by participants to ensure their safety and protection (APA, 2017). Additionally, I established the authenticity, credibility, and trustworthiness of this study, excluding professional colleagues.

Methodology

To answer the research question, I used IPA as the research methodology. Polkinghorne (1989) stated that IPA focuses on capturing the experiences of individuals who share a common interest in a specific phenomenon. By using IPA, I was able to explore and document clinicians' experiences of the services provided to Black male IPV victims. IPA was suitable for this study in relation to participants' accounts and perceptions of the experiences explored.

Participant Selection Logic

A key goal in a qualitative study was choosing participants to answer the research question. According to Patton (2014), participants must share a common experience related to a specific phenomenon. Additionally, participants must voluntarily agree to participate, accept a semistructured interview, be audio-recorded, and provide permission for publication (J.W. Creswell & Poth, 2018).

Population

For this study, formal help-seeking involved services provided by mental health professionals, who are the target population for this research. These professionals were

clinicians who engaged with or offered services to Black male IPV victims. The following professionals were considered for the study: social workers, licensed therapists, mental health nurse practitioners, psychologists, and psychiatrists in the United States. Given their crucial role as service providers to victims of IPV, exploring clinicians' lived experiences was essential for gaining new insights into their unique perspectives.

Sampling Strategy and Logic

In a phenomenological study, the sample of participants is guided by the research question (Ravitch & Carl, 2019). Compared to quantitative research, which generally quantifies numeric data to answer why and how in research, the core of qualitative research explores experiences by asking open-ended questions to explain human behavior (Tenney et al., 2017). In this study, the participant sample was determined based on data saturation to address the research question. Using purposive and snowball sampling, I recruited mental health clinicians who met the study criteria to answer the research questions. According to Ravitch and Carl (2019), purposive sampling enables researchers to identify and recruit study participants to gather detailed information about a specific phenomenon. Additionally, snowball sampling involved asking current participants to refer other eligible individuals who met the study criteria to participate in the study (Whitehead & James, 2024).

For the recruitment process, I emailed and called clinicians on various online platforms. Upon initial contact, I explained the research problem and the study's purpose to gauge their interest. Participants who met the study criteria received an invitation to a

45- to 60-minute Zoom interview, which was audio-recorded. All participants were English-speaking and over 18 years old. The interviews were transcribed into a Word document. All data were manually coded in an Excel spreadsheet to facilitate transcription and to develop codes and themes for data analysis. The number of participants was determined based on data saturation.

Data saturation occurred when no new themes were identified by additional participants (G. Guest et al., 2012; G. Guest et al., 2020; Malterud et al., 2016). Boddy (2016) noted that a sample size of five may be sufficient to achieve data saturation in a homogeneous population. Gentles et al. (2015) also suggested that smaller sample sizes are better for generating rich data on participants' experiences. G. Guest et al. (2020) achieved data saturation with five to six interviews, as no new themes emerged with additional participants. Although there is no fixed sample size required for data saturation in qualitative research, a range of five to twenty-five participants is usually recommended (J. Creswell, 2013; S.G. Smith et al., 2017). In this study, I reached data saturation with nine licensed clinicians, as no new information was uncovered with the addition of further participants.

Instrumentation

In phenomenological research, the researcher is the primary instrument that facilitates and guides the study (J.A. Smith et al., 2012). As the researcher, I conducted semistructured interviews, posed open-ended questions, and gathered rich data from participants. According to J. Creswell (2013), researchers determine the method and

approach of the interview to address the research question. I accommodated participants' schedules and preferences by conducting interviews via Zoom at no cost to them. In this study, I served both as the researcher and the facilitator. In this role, I used an interview protocol (See Appendix A) as a tool to guide and streamline the interview process.

Ravitch and Carl (2019) stated that an interview protocol helps the researcher ask specific questions and follow-up prompts during interviews. In addition to using the interview guide, I employed effective communication strategies to enhance the interview process. According to Kreuter and Wray (2003), effective communication strategies enhance the delivery of information and increase its relevance to the audience.

During data collection, I used terminology that aligned with clinicians' roles as mental health providers to gather detailed and rich data. In addition to verbal communication, nonverbal cues played a crucial role in helping to deepen descriptions and interpretations from participants (Denham & Onwuegbuzie, 2013). This communication process was used to prompt and probe for information, seeking clarification to better understand lived experiences and to improve formal help-seeking among Black male IPV victims. All interviews were audio-recorded to ensure content validity. Because qualitative interviews are interactive (Begley, 1996), using an audio recorder enabled me to capture participants' verbatim responses, thereby maintaining the integrity of their responses (Busetto et al., 2020). I also enhanced data collection through note-taking and grouped content for transcription (Rutakumwa et al., 2020) and established connections between interviews. To reduce research bias, I verified content

validity against recorded responses as an additional measure (C.K. Russell & Gregory, 2003). Lastly, I conducted member checking to allow participants to review the transcription for feedback and clarification, to ensure content accuracy and validity (Birt et al., 2016).

Procedures for Recruitment, Participation, and Data Collection

In this qualitative research, I recruited participants, collected and analyzed data, and reported the findings. Before recruitment, I obtained IRB approval from Walden University. The ethics approval number for this study is (05-02-25-0838418). I contacted clinicians and mental health providers via phone and email through various online platforms. Interested clinicians who met the study's criteria were screened to determine their eligibility for inclusion. Those who met the inclusion criteria were invited to participate in the study and received informed consent. The consent form explained the purpose of the study, confidentiality and anonymity, voluntary participation, and the right to withdraw at any time without penalty or obligation. It also included an agreement to participate in a 45–60-minute interview and permission to be audio recorded. To accommodate participants' needs, I conducted interviews via Zoom. Data was collected through audio-recorded, in-depth, semistructured interviews, which I transcribed verbatim. I employed the same set of questions to gather clinicians' perspectives and experiences and used follow-up questions to clarify the context (Ravitch & Carl, 2019). I used Zoom to record participants' responses for transcription. To ensure accuracy, participants were asked to review and confirm their interview transcripts, which helped

clarify any misunderstandings. I stored all interview materials in a locked cabinet to maintain confidentiality and anonymity.

Data Analysis Plan

Data analysis was a key part of qualitative research. Data analysis involved transforming raw data from participants into codes and categories to uncover themes (J. Saldana, 2021). For data analysis, I applied both deductive and inductive reasoning, generating codes from the words, phrases, and statements provided by each participant (J.A. Smith et al., 2012). I carefully read and reread the raw data multiple times. I paid close attention to the language, tone, and expressions in participants' responses to interview questions (J.A. Smith et al., 2012). I searched for similarities in codes and categories and grouped emerging themes. Because qualitative data analysis is an iterative process, I also used emotional and structural coding to explore clinicians' lived experiences to identify common themes (J. Saldana, 2016). Finally, I supported the identified themes with direct quotes from participants to include in this study.

Issues of Trustworthiness

Rigor was established by ensuring the study was trustworthy. To ensure the trustworthiness of this qualitative study, four aspects were established: credibility, transferability, dependability, and confirmability (Anney, 2014). Credibility in a qualitative study refers to the confidence in the accuracy and validity of the findings (Ahmed, 2024). It is established when the researcher's findings accurately reflect the participants' experiences (Holloway & Wheeler, 1995). To maintain credibility, I used

member-checking with each participant to review their interview summary and confirmed that my interpretation accurately reflected their experience. Participants verified the accuracy of the summarized data. Member checking prevented internal conflicts in the analysis and interpretation of data collected during the study, which ensured the accuracy of the final report (Guba, 1981).

Transferability in a qualitative study refers to the extent to which the findings can be applied to other populations, based on descriptions of sampling factors such as demographic location, the number and characteristics of participants, and the timeframe of data collection and analysis (Bitsch, 2005; Shenton, 2004). The overall purpose of the study was to explore clinicians' lived experiences in treating Black male victims of IPV. Therefore, I ensured transferability through detailed descriptions, allowing readers to assess the similarities in experiences.

Dependability in a qualitative study ensures that proper research practices were followed and the findings are reliable and consistent enough to be replicated by other researchers (Shenton, 2004). I establish dependability through member checking, where participants review the transcribed data to verify its accuracy and intended meaning. Using participants as members in the checking process, the interview protocol, observation notes, and audio recordings serve as cross-references made by the participants (Schwandt et al., 2007).

Confirmability is the interpretation of data that can be verified by other researchers (Anney, 2014). The study was validated when the interpretation of data

analysis was based on an accurate representation of respondents' experiences, rather than the researchers'. Confirmability was maintained through the researcher's reflexive journal, interview protocol, and demographic questionnaire, which supported the data interpretation and analysis, thereby demonstrating the transparency of the study to auditors.

Reflexivity in qualitative research requires researchers to critically examine personal biases, assumptions, preconceived notions, and how these may affect the study (Korstjens & Moser, 2018). Maxwell (2013) asserted that reflexivity not only helps shape the researchers' personal goals and desires concerning the research but also identifies and addresses flaws in a study. In this study, I exercised reflexivity by using interview protocols, observation notes, bracketing, audio-recorded interviews, and researching journals, as well as seeking feedback, support, and guidance from my chairs to minimize personal biases and assumptions.

Ethical Procedures

Adhering to ethical procedures is essential in research involving human participants (Principle 3.04, APA, 2017). To uphold ethical standards, this study obtained approval from the Walden University Institutional Review Board (IRB). The IRB proposal confirmed that there was no risk or harm to participants. I also implemented measures and protected the rights and well-being of participants. I began recruitment after I received approval from the IRB. Once approved, I recruited individuals who met the study criteria to help answer the research questions. Participants understood that they

could choose to participate or withdraw at any time without penalty and provided informed consent to be interviewed, audio recorded, and have their data published. Interviews were conducted via Zoom with all nine participants. I maintained the credibility and integrity of this research by excluding professional colleagues and dual relationships (APA, 2017, Principal 3.05). I kept all data, including field notes, audio recordings, reflexive notes, and interview protocols, in a locked cabinet accessible only to me for the protection and privacy of participants. These records are securely stored and would be destroyed after five years, as required by Walden University. I assigned numbers to participants to enhance privacy and protection. Finally, participants received a \$10 Amazon e-gift card as a token of appreciation for their participation.

Summary

In chapter 3, I used a phenomenological approach to explore the lived experiences of clinicians who treat Black males who have experienced IPV. I also gathered rich, in-depth data about clinicians' experiences as mental health providers to Black male IPV victims. To accurately represent clinicians' experiences, I discussed various components of the study methodology. I addressed trustworthiness through credibility, transferability, dependability, and confirmability. I explained the ethical procedures approved by Walden University IRB, followed by a summary of Chapter 4. In chapter four, I describe the study setting and provide demographic information about the research participants. I explain data collection and analysis procedures. Lastly, I present evidence of trustworthiness, study findings, and a summary of the key points.

Chapter 4: Results

The subject of IPV against men has been largely overlooked for many years. Researchers have demonstrated that men are and have been victims of abuse in intimate partner relationships (E.A. Bates et al., 2019; Bates, 2020a, 2020b; A.L. Coker et al., 2021; Scott-Storey et al., 2022). However, the feminist perspective on men and masculinity greatly influences how men seek help in IPV situations. Although studies have shown that IPV is often perpetrated in both directions (A. M. Brown & Ismail, 2019), society's portrayal of men as perpetrators of violence in intimate relationships remains a major barrier for male victims trying to access formal help. For Black men, who are a marginalized group, mental health clinicians are essential service providers in their recovery process.

The purpose of this IPA study was to explore the lived experiences of clinicians who treat Black males affected by IPV. The study was guided by Sue's (2001) theoretical model. I gained insights into clinicians' experiences by addressing the following research question: What are the lived experiences of clinicians who treat Black males who have experienced IPV? I used an IPA research design and collected data through semistructured interviews, asking open-ended questions. These questions were intended to encourage dialogue with participants to elicit clinicians' experiences of the phenomenon. Participants were prompted and probed to ensure a clear understanding of their experiences using clarification and follow-up questions.

In this chapter, I describe the settings, participants' demographics, method used to collect data, and analysis procedures for the emerging themes. I also discuss and provide evidence of trustworthiness, as well as discrepancies in data and the study results. Lastly, I offer a summary of the study and an introduction to Chapter 5.

Setting

The geographic setting for this study was Texas. All interviews took place over the Zoom platform. The security features of Zoom enabled me to record interviews for data management. Nine participants responded to an email and phone invitation and agreed to participate in an interview. Once we agreed on a scheduled day, date, and time at no cost to the participant, a Zoom link was sent via email the day before the meeting. To ensure participants had access, I copied the Zoom link and forwarded it to participants' email addresses. Each participant connected to Zoom for their interview. The interviews were conducted in a quiet and private setting, and all nine interviews proceeded without interruption.

Demographics

This qualitative study sought to explore the lived experiences of clinicians who treat Black males who have experienced IPV. Nine clinicians who had provided services to Black male victims of IPV were recruited. Six women were identified as African American/Black, one as Hispanic American, and two men were identified as African American/Black. Table 1 provides a demographic overview of the participants.

Table 1*Demographic Overview of Research Participants*

Participant	Age group	Race and ethnicity	Credential	Experience in practice (years)	Treatment population
Participant 1	45–55	Black, African American	MA, LMSW	9	Males, females, African Americans, Hispanics, Whites, Asians, Indonesians, Africans, multiracial, and Indians. Mostly minorities
Participant 2	45–55	Black, African American	MA, LMSW	9	Males, females, ages 18 and up, LGBTQ+, transgenders, Latinos, Hispanics, and minorities
Participant 3	55–60	Hispanic, Mexican American	MA, LPC	5	Whites, minorities, Hispanic, LGBTQ+
Participant 4	40–50	Black, African American	MA, LPC	19	Mixed population, males and females
Participant 5	30–40	Black, African American	MA, LPC	3	Males, females, teenagers, younger adults, adults, Whites, Blacks, Latinos, American Indians, Native Americans
Participant 6	30–40	Black, African American	MA, LPC, LCDC	5	Males, females, couples, children, older adults
Participant 7	30–40	Black, African American	MA, LSW	5	Veterans, active-duty military. Mostly minorities.
Participant 8	30–40	Black, African American	MA, LPC	2	Men, women, teenagers, Hispanics, and the majority Blacks
Participant 9	25–34	Black, African American	MA, LMSW, LCDC	2.5	Men, women, Hispanics, Whites, Asians, African Americans, Pacific Islanders, Africans. The majority of Blacks.

Data Collection

Recruitment for this study commenced only after I obtained approval from the Walden University Institutional Review Board. Recruitment began on May 5, 2025, and concluded on July 13, 2025. “Recruitment ceased upon reaching data saturation, as the addition of new participants from this homogeneous population yielded no new insights (Boddy, 2016; G. Guest et al., 2020). I initiated the first phase of recruitment through purposeful sampling. I made phone calls and sent emails to published clinicians on various online platforms. To those who responded to my calls, emails, and voice messages, I introduced myself and my affiliation with Walden University as a Ph.D. student working on my dissertation. I explained the purpose of the study to explore clinicians’ experiences in treating Black male IPV victims. I also provided details about the interview duration, the platform, and the member-checking process, in which transcribed data are sent back to participants for review to ensure accurate representation of their intent. I answered participants’ questions and used the initial contact to build rapport, warmth, and a sense of comfort. Participants who met the study criteria expressed interest and agreed to a 45–60-minute Zoom interview with audio recording. They received an email invitation to participate with informed consent, and I offered participants the opportunity to ask questions. I also directed clinicians to Walden University’s IRB and to reference the IRB approval number should they have any questions or concerns. Participants selected a day, date, and time for their interview. On the day of each interview, I first greeted participants, thanked them for their time and

willingness to participate, and addressed any questions they had. Following this, I collected their signed consent form before beginning the interview. I reminded them of their right to omit questions or terminate the interview at any point without consequence. All nine participants consented to the audio recording.

Data was collected through in-depth, semistructured interviews. I asked each participant open-ended questions, using probing and clarification to ensure understanding without obscuring their intent. The interview questions were consistent for all nine participants (see Appendix A). Aside from one interview that lasted 22 minutes, all eight interviews exceeded 60 minutes and ranged from 1 hour to 1 hour and 40 minutes, depending on the participants' responses. After asking initial demographic questions to help participants feel comfortable, they answered the interview questions and shared their experiences as service providers to Black men. Through snowball sampling, participants referred their colleagues to the study after being interviewed. Snowball sampling involved existing participants recruiting known colleagues who met the study criteria to participate (Patton, 2014).

Immediately after interviewing all nine clinicians, I transcribed the interviews into a Word document and reviewed them for accuracy, ensuring the content validity of participants' responses. The transcribed data was then sent to each participant via email for them to review, verify its accuracy, content, and intent, and provide any necessary clarification, corrections, and feedback. Besides minor grammatical errors, each member approved the transcription as accurate and reflective of their intent. This process of

member checking was essential to validate the research's accuracy, validity, credibility, and trustworthiness (Birt et al., 2016). All related research documents—including the USB drive, transcripts, and consent form—are stored in a locked cabinet that is only accessible to me.

Variation in Data Collection

There were some deviations from the original data collection plan. This study aimed to recruit clinicians from different states. However, due to recruitment challenges, participants who responded were primarily from Texas and Chicago. Another deviation was the length of each participant's interview. I expected each interview to last between 45 and 60 minutes. However, one interview ranged from 22 minutes to just under 45 minutes, considering the participants' schedules. Additionally, an unusual situation arose when one participant requested the interview questions in advance of their scheduled interview. Another participant, passionate about the research topic, asked to continue the interview, extending it beyond the allotted 60 minutes after her client canceled their scheduled session. The expressions of these two participants did not negatively impact the interviews.

Data Analysis

I began data analysis after I verified the accuracy of all participant data through member checking. The qualitative nature of the study allowed me to explore clinicians' lived experiences as service providers to Black male IPV victims. I conducted data analysis through manual coding to gain a deeper understanding of participants'

experiences by immersing myself in the data. Rather than using qualitative software like NVivo, I used manual coding to transcribe data. I listened to the audio recordings on different days and reread clinicians' responses, paying close attention to verbatim responses and how the clinicians expressed their experiences. I focused on identifying similarities and differences in responses to each interview question. I used different colors of highlighters to mark important phrases and words that described experiences. I applied both inductive and deductive reasoning to categorize them. These codes and categories were organized into an Excel spreadsheet for better data management. After several days of reflection, I identified seven meaningful themes that remained closely connected to the data, as expressed in the participants' responses. The utilization of manual coding offered a distinct analytical perspective, facilitating a rich capture of the lived experiences of clinicians providing services to Black male IPV victims.

Evidence of Trustworthiness

Credibility

Credibility refers to the extent to which the researchers' findings accurately reflect the reality experienced by the participants (Ahmed, 2024). As the researcher, I played a key role in this study from planning to completion. I recruited, screened, and interviewed participants who met the study criteria. I also analyzed and reported the findings. I maintained credibility by ensuring the findings accurately reflected participants' lived experiences. I used member checking to verify the accuracy of my interpretation of their interview responses. I solicited feedback and clarification from

each participant during the member checking process. I incorporated any input received into the data analysis. Additionally, I engaged in prolonged engagement and reflexivity throughout the interview process. I checked my personal biases through journaling and reflexive notes. I maintained transparency with participants and answered their questions about both personal and professional interests, creating a comfortable environment before and after the interviews. I reflected on previous insensitivity toward non-minority counselors working with Black male IPV victims to recognize that minority counselors also carry biases and prejudices. I reflected on the findings that racial stigma, discrimination, and systemic racism against Black men are not just racially motivated but are part of a broader societal issue.

Transferability

In a qualitative study, transferability refers to the extent to which the findings can be applied to the specific population studied, rather than to a broader group (Guba, 1981). This study was conducted to understand the lived experiences of clinicians who treat Black males who have experienced IPV. To promote transferability, I employed detailed and rich descriptions. I incorporated direct quotes from participants, so readers could identify commonalities in their experiences.

Dependability

Dependability in research upholds the logic and accuracy of the study (Ahmed, 2024). The researcher should report the entire process objectively and without opinions. Reporting dependability is essential because it provides a blueprint for other researchers

to replicate the study, considering the exact nature, population, and settings (Anney, 2014). To ensure dependability in this study, I provided detailed information on every step, from the recruitment process to the final analysis of results, under the guidance of my dissertation chairs.

Confirmability

Confirmability requires researchers to maintain impartiality and objectivity in their findings, ensuring they are free from biases and personal preferences (Anney, 2014). To ensure confirmability, I relied on participants through member checking to verify that the expressions in my transcribed transcript accurately reflected their lived experiences and were not my own interpretations. I also used reflexive journaling to document my thoughts, biases, and reflections throughout the process, as an additional measure to promote transparency and minimize subjectivity.

Results

Nine licensed clinicians participated in this research study. All participants had experience in treating Black male victims of IPV. I answered the main research question using quotes from the transcripts. A total of 16 questions in my interview protocol were used to elicit rich and in-depth descriptions of participants' experiences. I read through the transcripts and analyzed the responses to the prompts and questions in my interview protocol. The following seven themes were identified: Relatable, Building Trust in Therapeutic Spaces, Eliminating Biases, Stigma and Shame, Access to Legal Services

and Support, Access to Community Services and Support, Culturally Based Training and Education, and Access to Resources.

Discrepant Case

A discrepant case in a qualitative study aims to test the validity of the research. It serves as the foundation on which the researcher carefully examines supporting data and discrepancies to decide whether to retain or modify the conclusion (Maxwell, 2013). In this research, the discrepant case was that one participant indicated their White counterpart were equipped to counsel Black male victims of IPV, while the other eight participants cited their race, ethnicity, and culture as reasons for Black men to seek their services. Additionally, participants reported that Black male IPV victims often felt White clinicians were not relatable, felt judged, and misunderstood.

Theme 1: Relatable

As participants discussed their lived experiences as clinicians who treat Black male victims of IPV, a common theme of relatability emerged among all participants.

- “My experience with treating them is emotional, sometimes hearing what they have been through. It grows me not only as the clinician but as a person, to where we as a society need to be a bit more kind and a bit more compassionate to people because we don’t know what they’ve been through.”
(Participant 1)

- “I identify very well because I was a victim myself. I was a victim of assault by ... on several occasions. Because of that, I shared that with my clients, and instantly I built a rapport with them just like that.” (Participant 2)
- “It comes down to empathy. That I know what it’s like to be a minority in a small rural town.” (Participant 3)
- “I know for sure from my own experience that it can be daunting. Because you have to do self-reflection in order to continue growing, and sometimes people don’t want to do that part or they’re not ready to.” (Participant 4)
- “I think that I have had them say that they specifically sought out Black females for like safety reasons and someone who does identify with who they are, and what their experience may have been.” (Participant 5)
- “Hearing these things, having grown up in an abusive household myself, it’s emotional, and it’s sad, and it’s frustrating.” (Participant 6)
- “I would say being able to see where I have been too, remembering the purpose, although I can identify with it.” (Participant 7)
- “I don’t think that people want to come to anyone who hasn’t been through anything, and so I’m a big fan of saying that we are more alike than different.” (Participant 8)
- “I’ve also experienced IPV, and I didn’t realize that’s what happened to me until way later, after my own therapist helped me connect some dots.” (Participant 9)

Theme 2: Building Trust in Therapeutic Spaces

Participants emphasized the importance of this theme, as reflected in the following quotes.

- “With the Black population, counseling has not always been supported, or therapy has not always been supported. It’s always been more of what happened in my home or what happened in my life stays here in this house...but the clinicians have to be able to make them feel comfortable to discuss that.” (Participant 1)
- “I think that the best area is what I mentioned is building rapport. I can’t stress how critical it is to build rapport with the Black male. If they’re not bought in, they’re gone, they’re gone just like that.” (Participant 2)
- “Therapeutic alliance, again, it’s about building rapport. If someone doesn’t feel safe with you, there’s an impairment there which could control the therapeutic alliance, may suffer.” (Participant 5)
- “I respect the diversity within each human being, and so while I dig into concepts and theories and different philosophies, I allow them to tell me their story.” (Participant 7)
- “There becomes a point where self-disclosure in counseling can become harmful rather than helpful, and so a lot of times it becomes easier for men to know, hey, you’re not alone in this space, and I am also a victim and I

survived that, and I've grown from that, and I have moved forward from that.”

(Participant 9)

Theme 3: Eliminating Biases, Stigma, and Shame

Participants discussed the importance of addressing these issues in clinical settings.

- “I need my White counterpart to understand that for a Black man to come in and to admit that I've been abused, it takes a lot out of them, and so they should not be dismissed, you know, validate their feelings, give them the same support you would give a Caucasian person who's been through it.”

(Participant 1)

- “So many people [victims of IPV] have the mindset that I'm the only one going through this. Nobody will understand. I'm so embarrassed, I'm so ashamed that nobody's going to understand this.” (Participant 2)
- “Whether the male is the victim or the perpetrator, they're automatically seen as the perpetrator because they are a Black male, and even if they are the ones that are getting abused, they're still most cases, are the ones that's getting in trouble and that's going to jail or having the reprimand or whatever it is.”

(Participant 4)

- “There are people who may or may not have the cultural understanding and contextual background, and the knowledge to provide services without judgment. There's this within the culture stigma of you know, we do hard

things, and so this, you should be OK with this thing, right, this thing

happened to you, toughen it up, kind of mindset.” (Participant 5)

- “I definitely have to put my biases aside because sometimes it’s still hard to believe men are being abused right.” (Participant 8)
- “I think for me it’s really been managing bias and countertransference. Like I’ve had my own IPV experience, and so a lot of times it can be hard for me to keep myself in check when I hear stories that align closely to what I experience.” (Participant 9)

Theme 4: Access to Legal Services and Support

Participants reported that the responsibility of reporting abuse was with the client. a theme echoed by the participants.

- “We tell people it is your responsibility to make sure to report the abuse, so that’s really not up to us; it’s up to them.” (participant 3).
- “I think it’s important for men and Black men because, as we talked about, it doesn’t take much. Sometimes it doesn’t take anything for a Black man to lose his life in this country, and so having a paper trail showing these instances of this other person doing something.” (Participant 1)
- “I think sometimes more than anything, it’s dismissed and not looked at, or talked about, or you know police reports isn’t even a thought because one, the embarrassment and shame but also you know who’s going to believe, or the police officers will have comments or you know, they’ll waive it off or you

know, whatever; so just the lack of respect and attention to them [Black men victims of IPV] and their experience.” (Participant 5)

- “I think that when it comes to men, once they mess up, do they have a second chance or a third chance? because I think other ethnicities, or even when it comes to women, they get a lot of chances and a lot of passes, but when it comes to Black men, I feel like if they don’t do something right the first time, then all doors are closed. So, are we also giving them the same opportunity to pick themselves back up again and try again? Can they continue to try again until they get it right? I just hope that when people read your dissertation, it gives them a different perspective of how to handle Black men when it comes to intimate partner relationships.” (Participant 8)
- “I think that there is a lot of protection legally for women who experience IPV, but not for men.” (Participant 9)

Theme 5: Access to Community Services and Support

This theme was an emerging theme from participants.

- “I do try to encourage men’s groups or going to men’s groups. Especially with my African American clients, my Black clients, I definitely try to encourage [them] to get into men’s groups. Like Black male groups or church groups. Things that will help to provide them with some level of encouragement, or strength, or seeing other Black men in a different light, or some level of

leadership. Like seeing Black men in a leadership role where they don't feel so inferior or feel like they can't continue." (Participant 4)

- "Well, there's a standard typical community resources that are available. Homeless shelters and battered shelters. It's typically says for women, but there are places in the community that would also provide support to men as well." (Participant 5)
- "For clinicians, you know, we do our part with resources, just holding the spaces, but for Black men to let other Black men know that it is OK to know where they are able to communicate their emotions using the tools that they have. To tell the friend, right, Black men typically hang out with Black men. Self-advocating for your friends, for men that you know may be going through it in their relationships, even if it isn't to the full extent that they experienced it." (Participant 7)
- "I would definitely say housing, and let me further that. As we know in our community, a lot of times women are the holders of the apartment, the leases, the mortgages, and things like. And a lot of times, when men get into relationships with those women, a lot of times, if we're just being honest, they just move in with that woman right, and so it's very easy for that woman to say Hey, get out. You gotta go right, and what happens after that, right, so I think that housing is very, very important to have space, or, for some reason,

they get custody of their children right, so having services for fathers and children. Also, like I said, therapy.” (Participant 8)

Theme 6: Culturally Based Training and Education

This was the emerging theme that was echoed by participants.

- “Again, there’s not a lot out there [culturally based resources]. Again, I just use a universal skill set.” (Participant 2)
- “I’d like to learn more about how to help minorities, to be certain.” (Participant 3)
- “The experience I have had [working with Black men] is having the clients that have come to me during my schoolwork.” (Participant 4)
- “My strongest assets is me continuing to stay trained, me continuing to garner more information and more understanding of the cultural context and the impact of what trauma does to Black men; and that’s through continuing training and education for myself, that in connecting and knowing in my community with regard to resources and if the situation comes up, I don’t have to feel like I’m scrambling but that there is a clear path to access whatever shortfall I don’t have here in the clinic.” (Participant 5)
- “I don’t think there’s anything specific that I have within the company I work for. It’s more all-inclusive.” (Participant 7)
- “I do a lot of CEUs segments where we talk about cultural competency and we talk about working with different ethnicities.” (Participant 8)

- “I think there needs to be more providers that look like me doing the work. I think there’s been a lot of growth in the Black providers period, but Black male providers, we need to come together and target our own population better. And that means us being in contact with each other.” (Participant 9)

Theme 7: Access to Resources

The following quotes emerged from participants.

- “I will say the resources needed are more access to care. Therapy is one, support groups are another. Mental health care and having therapy available to them [Black men], mentorship, of course, that takes money itself.” (Participant 1)
- “Professional challenges are that there are not enough resources out there for coping skills for the male victim, so what you do is you basically look at women victims and just apply them to men because there’s not enough research out there for men.” (Participant 2)
- “Honestly, I could probably say more training on dealing with clients with IPV. I don’t feel like there’s a lot of training or CEUs, even resources.” (Participant 4)
- “I would say finances, right? For those who have care, they can access services. For those who do not have care, do not have the finances, do not know that there is support available, you know, What programs are we developing and marketing to those underserved populations so that they know

that hey this counseling agency provides this specialty service, and if I don't have money to pay, they have a program that will get me the services and the support that I needed. So, to me, that is a huge part of the gap, and individuals get services and support.” (Participant 5)

- “Definitely training for sure. I don't even know that there's adequate training out there for which is why I said this is such an important topic.” (Participant 6)

Summary

The purpose of this study explored the lived experiences of clinicians who treat Black males who have experienced IPV. A semistructured interview was conducted via Zoom. Data was collected from clinicians and mental health providers who treat Black male IPV victims. The analysis was based on data from nine participants. Seven themes emerged to answer the research questions: Relatable, Building Trust in Therapeutic Spaces, Eliminating Biases, Stigma and Shame, Access to Legal Services and Support, Access to Community Services and Support, Culturally Based Training and Education, and Access to Resources. The results reflected clinicians' needs and support in several areas of the services they provide to Black male IPV victims. In this chapter, I presented the seven emerging themes. In Chapter 5, I provide an interpretation of the findings, discuss the study's limitations, offer recommendations for future research, and outline the implications for promoting positive social change. I conclude chapter 5 with a detailed summary.

Chapter 5: Discussion, Conclusions, and Recommendations

This phenomenological study aimed to explore the lived experiences of clinicians who treat Black males who have experienced IPV. The literature review in Chapter Two focused on the help-seeking behaviors of men involved in domestic violence cases. The research showed that men encounter several barriers and challenges when seeking help as victims of abuse. These include shame, stigma, stereotypes, and gender bias from society and the legal system (E.A. Bates et al., 2019; Bates, 2020a, 2020b; Scott-Storey et al., 2022; Taylor et al., 2022). However, no studies were found on the lived experiences of clinicians who treat Black males who have experienced IPV in intimate relationships. Using IPA, this study allowed me to gain a deeper understanding and appreciation of the lived experiences of clinicians who have worked with Black male victims of IPV, thus filling a gap in the existing literature.

Interpretation of the Findings

Through the analysis of the interview data, clinicians reported positive aspects of their role as counselors. With their experience working with individuals from diverse racial and ethnic backgrounds, they developed knowledge, skills, and resources that were meaningful and purposeful, which allowed them to personalize each client's care. Participants shared that each of their client cases was unique, with different stories and experiences. Clinicians emphasized that their first impression was critical in establishing a therapeutic relationship with the Black male victim. Clinicians explained that building a strong alliance was vital, as was practicing flexibility and accountability in a therapeutic

setting. Participants noted that being understanding, compassionate, empathetic, and non-judgmental helped foster trust. Their ability to connect both professionally and personally served as a gateway to forming effective, meaningful relationships with their clients (Black men). Conversely, they also expressed the need for more funding and greater access to resources in the community, academia, and among professionals to serve male victims of IPV better. The interpretation of the analysis results from the nine clinicians I interviewed revealed seven themes: Relatable, Building Trust in the Therapeutic Spaces, Eliminating Biases, Stigma and Shame, Access to Legal Services and Support, Access to Community Services and Support, Culturally Based Training and Education, and Access to Resources. Identifying these themes helped me gain insight and perspective as clinicians reflected on their experiences.

Theme 1: Relatable

Clinicians approached treatment with empathy, caring, understanding, and compassion in the services they provided to Black male victims of IPV. Whether through personal experiences, professional exposure, or the experiences of a loved one, participants expressed their ability to empathize with their Black male clients regarding the negative impact of abuse on mental, emotional, and physical health. White and Chen (2024) found that counselors' ability to connect with their clients through social media use helped provide supportive care despite differences in experiences and reality. Aish et al.'s (2018) study highlighted that through relatability, students built a successful path that improved their self-efficacy and self-development as they shared similar

backgrounds, interests, and passions with their role models. These findings confirmed research on the positive outcomes in clinical counseling when clients and therapists found common ground and appreciated each other's experiences.

Theme 2: Building Trust in Therapeutic Spaces

Participants emphasized the importance of building trust as the foundation for establishing a therapeutic relationship with their Black clients. Without a foundation of trust, clinicians observed a higher incidence of premature termination among clients. Counselors stressed that their ability to establish trust early in treatment was crucial. S.T. Meier (2024) asserted that clients who developed a strong therapeutic alliance with counselors at the beginning are more likely to stay engaged and maintain stability in psychotherapy. Conversely, clients in a nontherapeutic environment are more likely to discontinue services (S.T. Meier, 2024). The research confirmed that men's lack of trust in therapy and therapists negatively impacts their reluctance to seek formal help (Bates, 2020a; Fisher & Kocsis, 2013; Kennedy et al., 2024).

Theme 3: Eliminating Biases, Stigma, and Shame

Counselors are encouraged to make every effort to understand how inequality impacts men and women, while equally valuing the experiences of both genders (Kees, 2005). Participants reported that unaddressed personal and professional biases, stigma, and shame could negatively impact treatment outcomes, emphasizing the need for self-awareness and self-reflection to mitigate these effects. Eliminating bias, stigma, and shame in the therapeutic space was a major theme echoed by participants. Clinicians in

this study noted that men's shame in identifying as victims of IPV and its related stigma hindered the therapeutic process. However, to normalize these concerns, they approached clients with humility and empathy, creating a judgment-free space for vulnerability in their services. Clinical practice necessitates that counselors maintain a vigilant awareness of how inherent biases and stereotypical perceptions concerning differences can adversely impact therapeutic outcomes (S.T. Meier, 2024). To best meet clients' needs, S.T. Meier and Davis (1990) suggested counselors take responsibility for understanding the self-perceived context of their clients. The findings from this study indicated that cultural stigma, internalized stigma, anticipated stigma, and personal and professional biases effectively suppress help-seeking behavior in victims of IPV (Overstreet & Quinn, 2013; Sue, 2001).

Theme 4: Access to Legal Services and Support

Leaving an abusive relationship is a complex issue for the victim. However, the situation becomes more challenging for men who face legal and administrative obstacles. Research has shown that men encountered more hostility within the legal system compared to women (J.L. Berger et al., 2016). In this study, clinicians expressed concerns about the significant differences in how men are treated within the criminal justice and court systems. Counselors highlighted their clients' viewpoints, including concerns and hesitations regarding interaction with law enforcement officers when reporting IPV. Clinicians noted that clients often voiced concerns over engaging with law enforcement, mentioning fears of arrest or potentially being shot if they sought help as

IPV victims. This finding supported previous research on men's perspectives and their reluctance to seek legal help as victims of IPV.

Theme 5: Access to Community Services and Support

During data collection, participants reported access to community resources for Black men. Although these resources—such as domestic shelters for women and children, housing, Food Stamps, and government-supported programs—were originally designed for women, they proved sufficient. However, participants suggested that additional resources, like a mentorship program, could better support other Black men by offering guidance and opportunities for growth. Clinicians advocated for community programs like Alcoholics Anonymous to be accessible to male victims of IPV while remaining private and anonymous. Participants noted that the lack of community support and access to mentorship programs made it difficult for men to leave abusive relationships. Counselors discovered that fears of loneliness, starting new relationships, accessing community support, and transitioning from familiar to unfamiliar situations influenced men's decisions to stay. The fear of change and starting over was also frequently mentioned. In this study, participants expressed that having access to strong community resources, support, and programs for Black men would be beneficial for those serving this population. The literature confirmed that men are underrepresented in community resources, and a lack of access to these services was linked to their underrepresentation in community support efforts (Dim & Lysova, 2022).

Theme 6: Culturally Based Training and Education

Education played a crucial role in promoting diversity in the counseling profession and other related fields. Participants pointed out that although Black men often hesitated to seek counseling, they tend to feel more understood by someone of the same race. They mentioned that some Black men sought counseling with Black therapist because of shared race and ethnicity. Additionally, they expressed that clinicians of color recognized and related to their struggles and experiences from a cultural perspective. Zane and Ku's (2014) research indicated that clients showed a preference for counselors of the same race. Similarly, Fisher et al. (1998) observed lower dropout rates and higher attendance when clients were paired with counselors of the same race. In Contrast, there was a higher dropout rate when Black men were placed in traditional counseling designed for White Europeans (E.W. Gandolf & Williams, 2001). These findings underscore the importance of culturally informed training, education, and diversity in clinical counseling and other fields that serve Black populations.

Theme 7: Access to Resources

In this study, clinicians had access to various treatment options, including Cognitive Behavioral Therapy, Dialectical Behavior Therapy, trauma-informed counseling, and solution-focused counseling; however, these options were not specifically tailored to the care of Black men. Besides clinicians' practical knowledge from experience, counselors were unaware of any available resources or training that adequately prepared them to treat Black men. Instead, they relied on conventional and

universal treatment modalities in therapy. Researchers suggested that overall, few intervention programs are equipped to address IPV among ethnic racial groups (S. Lipsky et al., 2006; E.W. Gandolf & Williams, 2001). The analysis showed that the nine participants interviewed for this study agreed they could benefit from knowledge and education on working with Black male IPV victims. This finding supports research indicating that mental health providers depend on their training, experience, knowledge, and skills to conduct clinical assessments of IPV victims in practice.

Multidimensional Cultural Competency

The theoretical framework for this study was Sue's (2001) multidimensional cultural competency. Sue's framework outlined the core principles and concepts essential in psychology. The literature emphasized the importance of fostering both individual and professional growth, as well as organizational and institutional development, to equip mental health providers with the skills necessary for multicultural counseling (Sue, 2001). For example, clinicians reported that some reasons Black men sought their services were related to their race and ethnicity, as well as their comfort and sense of relatedness. These clients received unbiased care, and their experiences were not dismissed but more fully understood. Recognizing how these factors can negatively impact the therapeutic outcomes for Black men in counseling, this theory raises awareness and promotes cultural competency among counselors working with individuals from diverse demographic backgrounds.

Limitations of the Study

While this study provided in-depth insights into the lived experiences of clinicians treating Black males who have experienced IPV, it was not without limitations. Recruitment continued until data saturation was reached (Saldana, 2016). As the researcher, I conducted interviews with nine participants and offered interpretations of the data. Due to the qualitative nature of the study, several limitations existed. One limitation was the challenge of recruiting clinicians who had the experience treating Black male IPV victims from multiple platforms. During the data collection process, my contact information was blocked, so I had to use secondary numbers to reach clinicians. This hindered my ability to recruit clinicians in different states. However, clinicians from Texas and Chicago responded to the study. Another limitation was the lack of diversity among the responding clinicians. Therefore, findings from this study were generalized to the clinicians who treated Black male IPV victims.

Recommendations

I conducted this study to address a gap in the literature regarding the lived experiences of clinicians who treat Black male victims of IPV. As participants shared their success stories, they also identified areas needing improvement. I recommend that future researchers replicate this study, focusing on clinicians from diverse racial and ethnic backgrounds in various regions. Additionally, I suggest future researchers explore the experiences of clinicians who identify as non-Black to better understand their work with Black male victims of IPV. Furthermore, I encourage future studies to investigate

clinicians' experiences with Black men in same-sex relationships and within the transgender community. Moreover, I recommend that future researchers replicate the study with men of different races and ethnicities (non-Black males) as IPV victims, along with their help-seeking experiences. Lastly, I propose that multicultural counseling be more than just a course in academia and training programs — it should be a required, ongoing curriculum designed to equip clinicians and other professionals.

Implications for Social Change

The results of this study highlighted several implications for positive social change. As participants shared their experiences as service providers to Black male victims of IPV, they acknowledged their limitations in serving the Black community. Clinicians reported that they are not adequately trained, prepared, or have access to resources designed for Black men. Nevertheless, they have learned to improvise with the resources available to women. Additionally, with limited access to culturally based resources in their profession, Clinicians had difficulty addressing the needs of this group. Participants indicated that they are only effective in serving the Black community based on the data they have collected over their years of practice. Counselors expressed the need for targeted educational training, access to culturally appropriate resources, and ongoing educational programs on minorities in their profession to improve treatment outcomes for Black men. The positive social change this study could potentially influence includes increasing access to community resources and programs for Black men in IPV relationships, implementing continuing educational programs and training

focused on ethnic minorities across various professions to improve treatment outcomes, providing educational training on cultural competency for clinicians regarding Black men who are IPV victims, encouraged mental health professionals to develop a framework for multicultural counseling to enhance the effectiveness of services offered to Black male victims of IPV, raised awareness to promote personal and professional growth among clinicians working with Black male IPV victims, foster organizational, academic, and institutional commitments to multicultural counseling across professions, inform stakeholders, policymakers, academia, institutions, and organizations to develop programs that address the specific needs of clinicians treating Black men in IPV relationships.

Reflection

The process of conducting this research necessitated a reflection on multiple contributing elements. I was not prepared for the wide range of emotions that the results would evoke. However, because the goal of this study was to explore the subjective experiences of clinicians, the results needed to remain unbiased and valid. Therefore, I withheld my professional role from participants and only revealed it to those who asked after the interview concluded. As a mental health nurse practitioner who serves individuals from diverse backgrounds, I lacked experience working with clinicians who treat Black male IPV victims. This study has helped me to better understand those experiences and the challenges clinicians face when working with abused Black men in intimate relationships. To maintain the study's credibility, I used a consistent level of

formality with every participant. I reviewed the purpose of the study, explained to participants their right to withdraw without penalty, and discussed the importance of member checking to verify content validity and intent from our initial contact. Once clinicians verbally agreed to participate, I used the same interview guide for all nine participants and sought clarification when needed. Throughout this process, I kept a journal to document my thoughts, perspectives, ideas, and preconceptions. I practiced self-reflection and monitored my biases as they emerged. I maintained a neutral stance while participants shared their experiences and during the transcription process for member checking. However, as I reviewed the transcribed data during coding to develop codes, categories, and themes, I felt a deep sense of empathy when I gained a better understanding and appreciation of clinicians' experiences and of Black male IPV victims who sought formal help. I relied on my chairs, who provided support, guidance, and feedback to help me gain a deeper understanding.

Conclusion

IPV is a global issue (WHO 2010, 2017). Survivors of IPV often experience a range of lasting consequences, including physical, psychological, and emotional trauma, as well as financial difficulties (A.L. Coker, 2021; L. Johnson et al., 2022; Lysova et al., 2023; M. Próspero & Fawson, 2010). Research showed that men face several challenges when seeking help from various professionals (Bates, 2020a, 2020b; A. Machado et al., 2024). Access to mental health support was critical for male IPV victims as they navigated and coped with the effects of the abuse. For this reason, creating a clinical

counseling platform to address these needs is essential. In a therapeutic setting, clinicians could foster personal growth by encouraging vulnerability, honesty, accountability, support, understanding, and empathy. These spaces provide Black individuals experiencing IPV with the tools, resources, and professional support needed to gain new perspectives on their situations. It is here that male victims of IPV can begin their healing journey. These reasons demonstrate why clinicians are essential as service providers for male IPV victims. As a society, we must not overlook these men but instead give them a voice and a safe space to share their experiences of abuse in a professional, nonjudgmental environment. A platform that values individual differences, lived experiences, and perspectives as victims of IPV.

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Appendix: Interview Questions

1. Please state your initials and your age group.
2. What race and ethnicity do you identify as?
3. What is your professional role and job title, and how long have you worked in your current position or role?
4. Please describe to me the different populations of individuals you provide services to.
5. What kinds of ethnic groups does your treatment population consist of? (e.g., minority vs. majority status)
6. Regarding your racial background, how do you identify with Black male victims of IPV?
7. How would you describe your experiences in treating Black male victims of IPV?
8. What challenges, both personal and professional, have you experienced or encountered treating this population?
9. How did you navigate through these challenges and obstacles?
10. Describe the protocol established within your organization for reporting abuse to law enforcement officers.
11. As a clinician, how do you handle each case independently?
12. What resources are available to you when treating Black male victims of IPV?

13. What resources have you used to treat Black male victims of IPV, and what resources have been given to your Black men throughout and post-treatment?
14. What are your strongest assets when treating Black men, and what areas do you see growth potential?
15. Describe the measures for maintaining therapeutic alliance post-treatment for continuous monitoring.
16. As a clinician, what areas of need, support, and resources do you anticipate as a service provider in the treatment of Black male victims of IPV?